BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF WASHINGTON

In the Matter of the Application regarding the Conversion and Acquisition of Control of Premera Blue Cross and its Affiliates	)	Docket No. G02-45

Adjudicative Hearing

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P R O C E E D I N G S

Tuesday, 9:00 a.m.

JUDGE FINKLE: Just quickly I have a number of rulings on the Alaska pre-filed testimony striking certain paragraphs, and I'll - so we don't delay the proceeding, I'll give you a summary ruling here.

As to the testimony of Michelle Brown, the following paragraphs are stricken, eight, nine; as to Joan Fisher, five, six, eight; as to Dennis McMillian, four, six, eight, nine; as to Karen Perdue, the paragraphs are not numbered, the pages do not seem to be numbered but page - what appears to be page four, the paragraph beginning "Demand dramatically exceeds" is stricken. The page beginning with the first paragraph "As a citizen of the state" is stricken. In other respects, the testimony will stand as presented. The basis of the ruling is analogous to the previous ruling striking the Medical Association witness paragraphs.

Are we ready with the next witness?

MR. KELLY: Yes, we are. Premera will call Barbara Dingfield.

BARBARA DINGFIELD, having been first sworn by the Judge, testified as follows:

JUDGE FINKLE: Please sit down.

DIRECT EXAMINATION

BY MR. KELLY:

Q And would you state your name, please?

A Barbara Dingfield.

Q And do you reside in Mt. Vernon, Washington?

A I do.

Q Do you also have an office in Seattle?

A I do.

Q I understand that you are a consultant with an organization called The Giving Practice. Could you describe what that organization is?

A Certainly. It's a nonprofit consulting company, which is affiliated with Philanthropy Northwest. And Philanthropy Northwest is the Regional Association of Grantmakers in the Pacific Northwest region.

Q I'd like to turn to your professional qualifications. Could you tell us what your formal education is.

A I have a bachelor of arts in mathematics from Swarthmore College, and a master of arts in economics from Columbia University in New York.

Q Could you give us an overview of the highlights of your professional experience?

A Certainly. In Boston, where I started working, I was with the nonprofit organization called the Association of Better -

For Better Housing, which I helped low-income families achieve home ownership. In moving to Seattle I then spent about seven years in city government, originally for the Department of Communication Development, where I managed redevelopments of downtown projects for the city. I then became a director of the Office of Policy Planning, appointed by Mayor Uhlman and then Mayor Royer. In 1979 I left city government and joined Wright Runstead & Company, where I was for about 14 years. And Wright Runstead is a manager and developer of commercial office buildings throughout the western states.

In '93 I left Wright Runstead & Company, and due to a lot of volunteer activities that I've been doing throughout my career, I totally switched careers and joined Microsoft as director of community affairs for Microsoft. And really worked with them for the next five years in doing the strategic planning for increasing their philanthropy, both regionally, nationally, and then ultimately internationally. I left Microsoft at the end of '99, and have been doing the consulting practice since then, which really works with private, public and corporate foundations in doing the strategic planning and grant making planning for - for a foundation.

Q Okay. Now, you mentioned you were involved in civic activities. Were you involved in United Way?

A I was. I was on the board of United Way of King County for nine years. I was chair of their strategic planning committee and ultimately became chair of the board of the United Way for King County.

Q Are you currently on any other boards?

A I am. I'm on the board of the YMCA of Greater Seattle. I'm also on the board of an organization called NPower, which helps other non-profits use technology effectively. And I'm on the Steering Committee for a program that the Gate's Foundation has funded called Sound Families, which helps homeless families find transitional housing.

Q Okay. In your resume, I believe there's enumerated many other organizations and boards that you've --

A Done a lot of volunteerism in my career, but among them, which might be relevant, I spent seven years on the board of Pacific Medical Center, at the time where it was converted from a public health hospital to a community hospital.

Q Now, your pre-filed testimony has been served and filed in this proceeding, and I'm going to ask you if you adopt that testimony?

A I do.

MR. KELLY: And Commissioner, Ms. Dingfield's testimony has been marked as hearing Exhibit P-15, and with her adoption of the testimony, Premera moves to admit P-15.

MS. deLEON: No objection.

MS. HAMBURGER: No objection.

JUDGE FINKLE: Admitted.

MR. KELLY: And her resume is P-16, and I'd also ask that that be admitted.

MS. deLEON: No objection.

MS. HAMBURGER: (Shakes head.)

JUDGE FINKLE: Admitted.

Q (By Mr. Kelly) I'd like to turn to how you became involved in this hearing.

A In the fall of 2003, Premera contacted our consulting practice to do some strategic planning for Premera Cares, which is the corporate giving program of Premera. After initial conversations about doing that work and their review of our consulting practice qualifications, they contacted us about helping in the thinking and planning for the foundations which would result from this conversion.

Q And for purposes of the testimony today, we'll refer to the foundation that would result if conversion goes forward as the Washington Foundation. What is your understanding of what the general purpose of the Washington Foundation would be?

A The overarching purpose is to promote the health of the residents of this state.

Q What were you asked to do in regard to the Washington Foundation, the discussions about it?

A Premera asked me and our consulting firm to facilitate meetings of leaders in the healthcare field to really brainstorm about what this foundation could do, and that's primarily what I did with Premera.

Q Okay. Now, how many meetings have you facilitated?

A I facilitated two meetings in October and then a subsequent one at the end of March of this year.

Q What types of organizations were invited to the, for example, the first meeting in early October and what were they asked to do?

A The organizations present at that meeting were basically nonprofit organizations, representing the public health community, educational institutions that train medical specialists, and foundations. That was kind of the overview.

Q Okay. I think you brought up with you your pre-filed testimony, Exhibit P-15, and I'd ask you to just turn to page - pages six and seven.

A Yes.

Q And at those pages you enumerate the 20 organizations that participated in this --

A That's right.

Q Did that group, rather than read them into the record again, include by way of example the Spokane Community College School of Nursing, the Washington State Public Health Association, the University of Washington School of Public

Health and Community Medicine, and the Washington Dental Service Foundation?

A That's correct.

Q Okay. And what were all of those organizations invited to discuss?

A In the first meeting what we primarily discussed was the unmet healthcare needs in Washington State, so we have some parameters within which to talk about what the ultimate purposes of the Washington Foundation would be.

Q So those are 20 organizations. Are there other interested parties whose suggestions you think should also be considered when the Washington Foundation actually begins to undertake any philanthropic efforts?

A Certainly this is not all-encompassing, there are many other stakeholders in the community which ultimately, if the foundation is created, would be invited to join in the conversation. So these were representative, certainly a good representation, but I do personally believe that there are others that would be invited as well to talk about the foundation.

Q Okay. For those 20 or so organizations, were their categories of needs that they came up with at the meeting?

A They did, and that is part of my testimony. But they did come up with sort of broad categories of unmet needs. And I don't know where --

Q We actually do have an illustrative chart. And this is actually taken from your pre-filed direct testimony?

A Right. They're essentially, if one looks at these, four categories of needs. The first one is really the shortage of medical personnel in the state, particularly in serving rural areas. The second one is the issue of basic access of - to medical care and the lack of access to many residents in the state. The third one is the issue of prevention screening and wellness education, which I think is generally recognized in the healthcare field as a way to make sure that people stay out of hospitals and needing more intense care. And finally that the safety net really doesn't include - the safety net that does exist doesn't include many subspecialties, and in many instances people simply cannot get care in certain fields.

Q Okay. Were there other significant observations that the participants made in addition to these categorizations of four basic areas?

A Well, I think one of the things that I thought was really interesting, we had people from Spokane at the meeting as well, and there was a lot of discussion about making sure that any programs or grants that the foundation could ultimately make would really be localized to meet the needs of the specific populations which they were serving, that the needs were not necessarily the same in rural areas, nor among

certain ethnic minorities, nor in every part of the state. So one size doesn't fit all when it comes to solving healthcare problems.

They also talked a lot about the opportunities that a foundation might afford to focus on some very pressing needs and not to kind of let the money be dispersed too widely but really to focus on some issues that they thought were of particular importance, and these are some of those.

Q Let me turn to another area of discussion, as I understand it at these meetings, and that was the possible purposes of the Washington Foundation. Was that discussed amongst --

A That was really deriving from these identification of unmet healthcare needs. We then moved to a discussion of what purposes, in very broad terms, the foundation could be - could address, and this was discussed as well at the second meeting. And the purposes actually that the group came up with have been incorporated into the Articles of Incorporation for the Washington Foundation that has been - that has been filed.

Q Okay. And we have an illustrative chart of that.

A No, that's not it.

MR. MITCHELL: Here we are.

Q (By Mr. Kelly) Okay. So, and this chart is somewhat small, this is a reflection of what is actually in the amended Form A under the Articles of Incorporation of the Washington

Foundation?

A That's right. And they're broadly stated if one - if you can read them, but they're broad purposes and the group did discuss these purposes quite specifically and concurred that they reflected what they felt that the purpose of the foundation should be.

Q Okay. Let's see if we can go back to - leaving this chart - well, actually let's go back to the previous one. How did the - did the participants have any examples, say, in regard to the first category of unmet needs, nursing, in terms of what the foundation might be able --

A Well, the problem in this that was identified with regard to nursing, for example, was that there were too few nursing faculty, and therefore not enough slots available to train nurses, and therefore would result in a shortage of nurses. So one of the ideas, for instance, that was suggested by the group was incentives to retain and develop faculty, scholarships or stipends that would be available to train and retain faculty. And also to provide other methods of educating nurses, be it a long-distance learning, et cetera, that would be an example in the nursing area.

Q So that might be able to serve local community needs through long distance --

A That's correct.

Q Okay. Now, were there any other ideas about how to improve

the number of healthcare professionals in rural areas that this group talked about?

A Yes. They talked about incentives or low-interest loans, which would be forgiven if people set up practices in rural areas. This is a program that indeed I think the Washington Dental Service has tried with dentists and have been quite successful. They talked about doing that on a much broader basis, recognizing that having healthcare professionals in rural areas really would be a way to improve the healthcare that was available in those communities.

Q That's on the provider side. How about for patients living in rural areas, any thoughts they had to this foundation?

A Yeah, often in rural areas, both due to low income, inaccessibility, and also some cultural barriers, it is often hard for people to get basic primary care. And there are a number of ways of addressing that. One is to find a more community clinic, which can be funded through foundations, and also to provide transportation and lodging when rural patients need the kind of tertiary care that you can get in large urban areas.

Q Okay. I think the other - the next category was unmet - was public health efforts. Did the participants have any specific thoughts about how the Washington Foundation might help to address those issues?

A Particularly among some groups, people representing the

American Cancer Society, the American Heart Association, the like, the real concern is there isn't sufficient education, outreach and screening available to people statewide, which really then is the prevention and the wellness education that you need and that a foundation could fund many of those kinds of community-based outreach and public health education programs.

Q Okay. Now, I take it that these are suggestions of the types of programs that might be supported, not any attempt to mandate anything, is that --

A Not at all. We all recognize that this was very preliminary thinking, and obviously as the foundation would get formed if the conversion is approved, many others would be involved in these discussions.

Q Okay. Let me turn to another area. Did the meeting participants have preliminary recommendations regarding some guiding principals that the Washington Foundation might follow so as to maximize the health impact on available dollars to meet unmet needs?

A They did, and these are not in any way binding but they did have some principals such as promoting systemic change, having initiatives which last for a long time, which was the sustainability, that they should be community based. I'm not going to read all of this, but they did.

Q Okay. And I'd like to turn now to the meeting that you

facilitated on March 30th, the most recent one. What happened there?

A On March 30th - first of all, there had been an amended Form A filed in February. And as a result of that amendment, as I understand it, the Attorney General's Office will have a significant role in appointing the boards of these foundations. So, a representative from the Attorney General's Office was invited to attend the meeting, as were representatives of Premera, who explained how the process and the structure of the foundations had changed since our prior meetings. There was also discussion of an advisory committee that might be formed by the Attorney General's Office to advise on the initial planning, work for the foundation, as well as potential - potentially as a nominating committee for the board of the foundation.

Q And was that group at that meeting conscious of the need to include others who hadn't attended the meeting?

A Absolutely. There has always been recognition that public county health officials might be included, other organizations; for instance, we didn't have many representatives from the mental health area or from the HIV/AIDS Organization, so yes, there was general recognition that other stakeholders would have to be at the table.

Q What further role, if any, would Premera have, is your understanding, in such future needs?

A During the March 30th meeting Premera made it clear that henceforth really this was the responsibility of the State, in particular the Attorney General's Office, if the conversion is approved, go forward with the planning and appointment of the board. Premera did say it would be willing to facilitate these meetings, just convening them. And as I understand, it has also said as part of its filing that funds would be available to both the Washington Foundation and the Alaska Foundation to do the preliminary planning work; $250,000 grants to each of the new foundations as well as additional loans.

Q This is a pretty obvious question but would those grants and loans be helpful to a foundation trying to get started?

A Certainly. Starting up a new foundation, given the work I have done with new foundations, it does require a lot of planning work, and clearly those funds would be useful.

Q Okay. Let me turn to the area of planning. As a general matter what approach, in your experience, do new charitable organizations take as they begin their operations?

A It's an exciting but difficult task. And what I discussed with the group was sort of several ways of going about it. First of all, obviously assessing what the healthcare needs are in a more systemic way. We had obviously done that somewhat, but really doing a broad-based, what I would call a scan of what the unmet healthcare needs are and meeting in

local communities with people that can articulate what the unmet healthcare needs are.

Then looking at the experience of other similar foundations across the country, then developing mission statements, guidelines, grant-making principles. Those are the kinds of steps that a new foundation would have to undertake in order to begin its work.

Q Okay. And would you recommend that the Washington Foundation undertake a planning process that would include those --

A I certainly would, and probably other things as well. Fortunately, there are some very good similar foundations across the country, so there are best practices and lessons learned which Washington could use as a basis for which to do its planning.

Q The final area I wanted to discuss with you is the level of funding that is available from other charitable organizations for unmet healthcare needs in Washington. What's the situation there?

A The largest foundation that focuses its funding specifically in Washington State, but more specifically in the Puget Sound area, is the Seattle Foundation, which is the community foundation. Its assets are about in the order of magnitude of about 300 million, of which only - and they make grants under 40 million a year, but only a small portion, I think it's less, about 20, 25 percent, are used for healthcare

purposes.

There are two large foundations which have been fairly recently created, one is the Paul Allen Foundation. They do fund some healthcare needs. Last year it was about, I think in the order of magnitude of about one and a half million dollars. So, not very great.

The Gate's Foundation, the largest foundation, not just in the state but in the country, devotes a lot of its attention to healthcare but it's global healthcare. It's healthcare in developing countries, in third-world countries, vaccines, prevention issues, which really don't relate directly to what the needs are in Washington State. They do fund some things in Washington State but do not focus on healthcare.

There are two other foundations, the Washington Foundation and the Comprehensive Health Foundation, which are both Washington based. They make grants less than two million dollars a year and are quite focused in what they do. So certainly they make a contribution, but the assets are not that large.

Q And finally, what is your view as to the importance of the Washington Foundation for the residents of Washington?

A Well, if the conversion is approved, I think this is an enormous opportunity in the state to really create a philanthropic entity which can serve the residents in

providing for many of the healthcare needs that our residents have and which are going unmet today.

Q Very good.

MR. KELLY: Those are all the questions I have of this witness.

CROSS-EXAMINATION

BY MS. deLEON:

Q Ms. Dingfield, I'm trying to understand the role that you played here.

A Sure.

Q You facilitated three meetings at Premera's request; is that correct?

A That's right.

Q And as a facilitator you wouldn't have actually had input into the brainstorming sessions themselves, would you have?

A No, I did what a facilitator usually does. But obviously given my background I knew a little bit about the subject matter.

Q Have you had any background in the healthcare field?

A Well, as I said, I served for seven years on the board of Pacific Medical Center, and other than that, no.

Q Have you ever worked for a health carrier?

A No, I have not.
Q So you facilitated some meetings for Premera regarding - in which 20 Washington nonprofit organizations participated; correct?
A That's right.
Q How are the 20 organizations selected?
A My understanding is that prior to my involvement, managers from Premera had sort of - had contacted a whole variety of community organizations and had met with them in smaller group meetings, and that these were among those that had been invited to those smaller group meetings.
Q So you had no input into the selection process?
A No, I did not.
Q Who designated what the purpose of those meetings would be?
A Well, we talked about that collectively, and obviously I talked about it with Premera. It was obvious that addressing - kind of getting to the purpose that the - purposes that the foundation would have was a process which would involve these organizations, but I certainly did that with Premera. I mean --
Q Did you set the agenda for the meetings or did Premera?
A I think I wrote a couple of the agendas. I think the first one they prepared the agenda and I think in the second and third ones I prepared the agenda.
Q How did you get selected to facilitate these meetings?

A As I said, it was - they - Premera Cares, which is the charitable arm of Premera, had contacted me to do strategic planning, and as a result of those conversations, really, I believe that someone that I met with, which were not the people that were dealing with the conversion, had suggested to some of the people within Premera that were working on the conversion that I might be of help to them.

Q When were you selected?

A I think my first meeting with Premera was in September of 2003, and then - yeah, I think it was - all of this happened in September of 2003.

Q Ms. Dingfield, you testified that the general purpose of the foundation would be to promote the health of the residents in Washington State; is that correct?

A That's right.

Q And who told you what this purpose would be?

A Told me? No one told me. I mean I - I did not come up with those words. It was - I mean - I'm not sure what you're getting at.

Q Is that your idea of what the purpose is, or did someone say this is the purpose of the foundation?

A I think the group as a whole, and then Premera translated that. I did not write those words.

Q At the time of your October meetings there was only a plan for one foundation; is that correct?

A That's correct.
Q And then there would be two charitable organizations, one for Washington and one for Alaska?
A That's my - that was my understanding.
Q So these meetings really only concerned the Washington charitable organization?
A That's correct. And these were representatives all from Washington State, did not include any people from Alaska.
Q And at the time of your October meetings there was no plan to amend the Form A to include one foundation, was there?
A Not that I was aware of, no.
Q Did you have any hand in amending the purposes section of the article three of the Articles of Incorporation for the Washington Foundation?
A That was kind of an iterative process, as many drafting processes are. I believe - I'm trying - we identified the unmet healthcare needs. Then we took a stab, we, by "we" I mean Premera and I went back and forth trying to derive from the conversations that were had what the purposes would be, and it was a drafting process which involved Premera, myself, and then it was given back to this group at the October 30th meeting, and there were some words missing at that meeting and additions to the purpose to the draft. And the final draft was prepared by Premera and circulated to all the participants at the meeting.

Q Did Premera tell you during these October meetings that it had planned to amend its Form A?
A I was not aware of that, no.
Q In your testimony on page eight, it says, on line 12 or thereabouts, "Participants in the smaller meetings had identified a number of significant unmet healthcare needs," and then they're summarized into four categories. Do you see that?
A Yes, I do.
Q What smaller meetings are you referring to?
A These were the meetings that I was not participating in that Premera management had with sub groups of these 20 organizations.
Q Do you personally have knowledge of a nursing faculty shortage in Washington?
A Do I have personal knowledge? No, I learned about it from the deans that were present at the meeting.
Q And where is the shortage?
A I believe, as I understood from the participants, that in almost all of the colleges of nursing there are - there's more demand for - students cannot be accepted because there's not sufficient faculty. And as I understood it, that's pretty much statewide.
Q Do you know of any reasons for the lack of doctors in rural areas?

A I can surmise from reading the papers and what I generally know. But basically it is, as I understand it, for many doctors going into practice, much more difficult to have a successful practice in rural areas. And since doctors like to work in groups, it is also more difficult to have a critical mass of doctors that are working together. And I think - frankly, I think their lifestyle preferences and preferences for affiliation with a research institute or a large teaching hospital, which obviously is available in large urban areas and not available in rural areas.

Q Did these meetings discuss how the foundation would address those issues?

A As I said, there was some discussion about using incentives, such as for giving student loans and other ways of encouraging doctors to spend at least part of their career in rural areas.

Q You go on to say in your testimony on page nine, talking about safety net issues. I guess I should define that on page eight. It says, "The fact that certain healthcare specialties," and then you go into describe mental health, dental and eye care, et cetera, "are not included in the health 'safety net.'" Could you define what you mean by safety net?

A I think what the participants were talking about was that Medicaid, which is a federal program, and also the basic

health plan, which is the state program, do not have coverage, to my understanding, in mental health, dental care and vision care, and therefore that lower-income people who do qualify for those programs cannot get those forms of care through the government programs that are available.

Q And did you discuss or did the participants discuss how the foundation could address this issue?

A It was discussed in a very broad way, which is that community clinics, which are often grant funded, could provide some of those services.

Q Also on your - in your testimony on page nine, the last paragraph, starting on line 18, I'm just going to read the last sentence to you, "The participants also discussed the potential benefits of having the Washington Foundation select healthcare issues as areas of focus." Were they anticipating that the foundation would not be restricted to just healthcare issues?

A No, the discussion was, if we - if we address every unmet healthcare need, that the dollars may not be as focused and may not solve problems, as if - rather than trying - for instance, one of the examples I think was on prevention and basic primary care. That if you really address issues of education about public health, wellness and basic primary care, that in fact you might be able to solve a lot of other healthcare problems. So it wasn't a matter of not addressing

- addressing things outside of healthcare, it was taking the arena of unmet healthcare needs and saying where can we focus to be most effective, where could the dollars created by this conversion, by the foundation be used most effectively.

Q You say on page 15 of your direct testimony that "There are relatively limited resources from other charitable organizations and foundations in Washington for unmet healthcare needs." That's correct?

A That's right.

Q Yet on pages six and seven you list 20 organizations, and many of them do provide charitable grants and address the healthcare needs of Washington. Isn't that also true?

A Yes, and they all pretty much said they needed more resources. I mean, that was the resounding theme among the group, whether they were educational institutions or nonprofits that do this kind of outreach, that they felt that they did not have the resources, sufficient resources to do what they believed was their mission.

Q Have you ever come across a nonprofit that said they had too much money?

A No, but I think that - that's - you know. I think they expressed - they gave very specific examples where if they had additional resources they could do better work for Washington residents. But...

Q Okay. Have you been asked to participate in future planning

sessions regarding the foundation?

A No, not at this point.

Q If the conversion is not approved, can Premera still partner with charitable organizations to do things to help meet the unmet needs of the health - of residents in Washington?

A Certainly. I mean, to the extent that the operating margins, if they are - currently Premera Cares I think has a budget of less than $500,000. I think it's in the three-to-$400,000 range. So obviously as in most corporations that comes out of the bottom line, if it's - and if those resources are available, yes.

MS. deLEON: I have no further questions.

CROSS-EXAMINATION

BY MS. HAMBURGER:

Q Good morning, Ms. Dingfield, I'm Ele Hamburger with the Premera Watch Coalition.

You testified that this group of 20 organizations was selected by Premera; is that right?

A That's right.

Q And they came up with this list of - or the previous meetings that were facilitated by Premera came up with those four categories?

A They came up with a whole list of unmet healthcare needs and then we tried in the meeting to categorize it.
Q To categorize them, okay. And for instance, a different group of 20 could have come up with a different set of needs, couldn't they?
A In theory, yes. I think in practice that would not happen since it was pretty broad based, you know - yes, I mean theoretically yes, but I doubt that that would happen given the scope of organizations that were included in this meeting.
Q So it's possible a different group could have put the lack of access to affordable health insurance as one of the primary categories, couldn't it?
A Affordable health insurance. I suppose lack of - I mean they did discuss some of that, they discussed the number of uninsured residents in the state of Washington, but it was all grouped under the issue of lack of access to healthcare, which has many different facets to it.
Q Well, there actually isn't a category of access to healthcare, you have that category of access to public education and basic needs; is that right? Is that where you're putting access to affordable health insurance?
A No. I - let me - if we look at page eight, it says "Lack of access to public health education and basic healthcare." That was really the issue of access to care. So, it's lack

of access to basic healthcare and public education.
Q So are you saying that the group identified the lack of affordable health insurance as part of that sub category?
A They never discussed health insurance. They discussed the fact that there are many people that do not have insurance. Some of it is because it's not affordable. There might be other reasons as well.
Q Do you think that's a significant problem in our state, lack of affordable health insurance?
A I think the problem is that there are many people that are not insured in our state for a variety of reasons, affordability is certainly one of them.
Q Now, you identified that there should be other groups involved in future discussions?
A Right.
Q Were other groups invited to the March 30th meeting?
A No, we pretty much decided to stay with the same group because it had been kind of a process that we had gone through with them.
Q So --
A So we did not broaden the group at that point.
Q And you have a number of representatives from nursing education facilities; is that right?
A That's right, as well as medical schools.
Q And do you know that Mr. Barlow serves on the board of the

Seattle University School of Nursing?
A I was aware of that, yes.
Q Now, the Washington State Nurses Association was not invited?
A No, it was not, to my knowledge.
Q And nor was a representative from the Washington State Hospital Association?
A Yes, we did. We had James Whitfield, I believe his name was, who was with the Washington - Washington Foundation, which is affiliated with the Washington Hospital Association, I believe.
Q But it's not the Washington State Hospital Association, is it?
A I don't believe it's the Washington State Hospital Association, but --
MR. KELLY: Could I ask that the witness be permitted to finish her answer?
JUDGE FINKLE: Please allow a delay. Thanks. Go ahead. Have you completed your answer?
A Yes, James Whitfield was a representative of the Washington Foundation, which I believe is an organization which is affiliated with the Washington Hospital Association, but I may be incorrect in that.
Q (By Ms. Hamburger) There was no representative from the Washington State Medical Association, was there?
A No, there was not.

Q And there was no one representing, for instance, the Children's Alliance?
A The Children's Alliance, which I'm very familiar with, was not there, but I - they focus on many issues of advocacy, from day care to others that I - is slightly different than healthcare issues, so...
Q They do work on healthcare issues --
A Among the array of things they do, yes.
Q Were participants at the meeting asked whether they had an opinion on whether the foundation or grantees should be able to engage in activities that are materially adverse to the interest of health insurers?
A That did not come up.
Q And so it didn't come up whether Premera should be able to sue the foundation or its grantees if they engage in activities that are materially adverse to the interests of health insurers?
A That was not discussed.
Q You testified that you expect in the future, if a foundation were to be created, that you would have a process - you would recommend a process that would be more inclusive; is that right?
A That's correct.
Q And a process that would include groups such as - groups that represent persons of color on healthcare issues or immigrant

healthcare issues?

A Certainly - I think there are two issues here. One is that there were certain issues, such as mental health community, HIV/AIDS community and so on, who really work with people that have those illnesses that were not part of the group. And secondly, I would think that there would be a community planning process that would reach out to the residents in general and stakeholders in general throughout the state, which would include the immigrant - you know, migrant worker population, people of ethnic minorities, people that live in very remote and rural areas, et cetera. So it's both reaching the residents that have certain needs as well as including other groups that represent other people that were not included in this.

Q So this process is not a substitute for the process that the attorney general might conduct?

A Not at all. I would expect that - in fact, that was part of the discussion of the attorney general, if she decided to create an advisory committee, would be much broader-brush planning.

MS. HAMBURGER: I have no further questions.

MR. KELLY: I just have a couple.

(Continued on next page.)

REDIRECT EXAMINATION

BY MR. KELLY:

Q If you could turn your attention either on page 11 of the pre-filed testimony or on the board. Under the bullet point "Measures that are included in article three," would you read into the record what the third bullet point says?

A The third bullet point is addressing the unmet healthcare needs of low-income, uninsured and underinsured populations.

Q So that would be one of the purposes for which the foundation --

A That's right.

Q Now, the final area of questioning, if the attorney general wanted to meet with the Washington State Nursing Association, Washington State Hospital Association, Washington State Medical Association, Children's Alliance and any other interested parties who have something to bring by way of thought to the table, what would you recommend that she do?

A Oh, absolute - I mean, I think that's essential in the next stages of planning, that all the stakeholders, and certainly providers are among the main stakeholders, that they be included in discussions.

MR. KELLY: That's all I have.

MS. deLEON: I have no questions.

MS. HAMBURGER: I just have one question.

RECROSS-EXAMINATION

BY MS. HAMBURGER:

Q You wouldn't recommend that the Washington State Hospital Association and the Washington State Medical Association and Nurses Association or the Children's Alliance be barred from serving - having members serve as board members of the new foundation, would you?

A The issue of board members is a very interesting one, and I've looked at what some of the foundation - similar foundations have done in other parts of the country. I think you can have anybody as a board member but you have to be very conscious of conflict-of-interest issues. And I think most of the foundations that exist that are derivative from healthcare conversions have very clear conflict-of-interest provisions. So, that does not mean someone cannot be a board member but would have to recuse himself or herself when there are any issues that create conflict of interest.

Q So, for instance, if Premera had a board member that wanted to serve on the board of the new foundation, that would be a potential conflict of interest?

A I would imagine so. And I believe they've actually said that they would not have anyone serving on the board for that very reason.

Q Thank you.

MR. KELLY: If I could ask permission to go back to redirect, there's one area I wanted to get to --

MR. FINKLE: Sure, go ahead.

REDIRECT EXAMINATION

BY MR. KELLY:

Q It was something that Ms. deLeon had asked about, the resources that various foundations have. What can you tell us about how foundation grants can be impactful, I guess the word is, far beyond the actual dollars --

A Well, it's clear that if you do good grant making you can really achieve change on a systemic basis. And what I mean by that is while hospitals throughout the state provide charitable care, those patients that are already in the hospital are severely ill, if you - and have no resources to pay. If those very same people can get basic primary care, preventative care, public health education, wellness care, they may never end up in that situation of being in the hospital. So by using resources, charitable philanthropic resources in a very targeted way, you can potentially affect the entire system by really improving the healthcare of the citizens and using those funds in a much more cost effective way than when they end up in the hospital and you have to

provide charitable care. So I think targeted philanthropy can be very effective whether it be in healthcare or other arenas.

MR. KELLY: That's all I have. Thank you.

MS. deLEON: Nothing.

CROSS-EXAMINATION

BY COMMISSIONER KREIDLER:

Q Ms. Dingfield, I'm curious on the issue related to unmet healthcare needs in rural areas. One of the issues that's frequently listed is the lack of availability, particularly in the individual market, of health insurance that's available for individuals. Was there any discussion at all on that particular issue of access to health insurance in rural areas as a part of the overall problem of unmet needs?

A There was certainly a discussion of the number of uninsured and the concern about the growing number of uninsured. It was at the same time I believe where the State was reducing the funds available for the basic health plan, which would enable some people in rural areas to get some primary care. So yes, it was discussed. There are no solutions - it's a tough, tough problem, the State's grappling with it, the federal government's grappling with it. There are not many

resources available. But there was a recognition that the lack of insurance is an issue in this state, and particularly in the individual market.

Q Is it fair to say that there was no discussion of what the impact would be in rural areas for access to affordable health insurance with a conversion of Premera from nonprofit to for-profit?

A The question is?

Q Was there no discussion in your meetings about the impact of conversion on the issues related to access to affordable health insurance?

A I see. The group really didn't discuss the impact of conversion per se. And they really were there to discuss the charitable foundation, not how the conversion itself would impact people. That really didn't come up in discussion, Commissioner.

Q Thank you.

JUDGE FINKLE: Any follow-up?

MR. KELLY: Not for us.

MS. deLEON: No.

MS. HAMBURGER: Not for us.

JUDGE FINKLE: Thank you. Please step down.

(Witness excused.)

MR. MITCHELL: Premera will call Lew Reid.

(Continued on next page.)

E. LEWIS REID, having been first sworn by the Judge, testified as follows:

JUDGE FINKLE: Please sit down.

DIRECT EXAMINATION

BY MR. MITCHELL:

Q Mr. Reid, would you please state your name and spell it for the record.

A Lewis Reid, L-E-W-I-S, R-E-I-D.

Q Mr. Reid, have you provided pre-filed direct testimony in this matter?

A Yes, I have.

Q Did you also prepare and submit an initial expert report and a supplemental expert report?

A Yes, I did.

Q Are those two reports incorporated by reference in your pre-filed direct testimony?

A Yes.

Q Is a copy of your resume also attached to your pre-filed direct testimony?

A Yes.

Q Mr. Reid, have you provided any pre-filed responsive

testimony?

A Yes.

Q Are excerpts from the depositions of Aaron Katz and Joseph Lundy attached as an exhibit to your pre-filed responsive testimony?

A Yes.

Q Mr. Reid, do you adopt all of your pre-filed direct and responsive testimony in this matter?

A Yes.

MR. MITCHELL: Your Honor, with Mr. Reid's adoption of his testimony previously filed and served in this matter, we would move the admission of Exhibits P-8 through P-13 inclusive.

MS. deLEON: No objection.

MS. HAMBURGER: No objection.

JUDGE FINKLE: Admitted.

(Exhibits P-8 through P-13 admitted.)

Q (By Mr. Mitchell) Mr. Reid, please describe your educational background.

A I had an electrical engineering degree from Princeton University, and got my law degree at Harvard Law School.

Q Can you describe your professional career, please, an overview?

A My professional career was primarily 35 years in law practice

in San Francisco, with three years out early in my career to work in the U.S. Senate, and some time as a lecturer in law in business planning at the law school at Berkeley. I retired from law practice in 1998 and ran the California Endowment, the private foundation, for two years, and I retired late in the year of 2000.

Q Mr. Reid, how did you first become involved in conversion matters?

A Well, in my private law practice I was involved in the mid '80s. I became involved in the conversion that created the Sierra Health Foundation in Sacramento. Then in the late '80s, early '90s I was involved in the conversion in San Diego of a group called the Community Care Network, which transferred its stock to a foundation called Alliance Healthcare Foundation. Then in early '94 I was hired by Blue Cross of California to help them on the project to create a private foundation, which was to - was to have a hundred million dollars as its corpus. And then in - I was doing the tax and corporate work on that. Then in June of 1994, when the Blue Cross/Blue Shield Association changed their rules to permit a for-profit corporation to hold a license, I was directed to make all deliberate haste to do the planning for a full-on conversion of Blue Cross of California. I worked on that essentially for two years until we closed the transaction on May 20th, 1996.

Q What was the result of the conversion of Blue Cross of California, Mr. Reid?

A Well, as the proposal here, we created two foundations, but not because we had two states. We created a 501(c)(4) organization, now called the California Healthcare Foundation, and it was the recipient of the stock of the converted entity. As it sold the stock, it distributed 80 percent of the proceeds to a 501(c)(3) private foundation called the California health - excuse me, the California Endowment. And the California Endowment is the organization that I ran.

Q Before we get to your joining the California Endowment in 1998, Mr. Reid, can you tell us what role you played in the two foundations that were created through the conversion of Blue Cross of California?

A At the time the conversion closed in May of '94, I ceased working for Blue Cross of California and started working as the outside general counsel for both of the foundations. And I continued as the outside general counsel for both foundations until I commenced running the California Endowment.

Q You said, I believe, that you ran the California Endowment from 1998 until your retirement in 2000, Mr. Reid. What have you been doing since you retired?

A Well, I've had my feet up on the ranch a lot of the time, but

I'm still on the board of the California Endowment. I'm on the board of the Hillblom Foundation, which is a private foundation that funds medical research, mainly in neurodegenerative diseases and diabetes. I've just gone on the board of the Buck Institute, which is a medical research institute that focuses on diseases of the aging. You will notice that I've taken an interest in aging.

And I'm on the board of some environmental groups, the American Land Conservancy, the Sonoma Land Trust, and a variety of other non-profits.

Q Mr. Reid, I'd like to now focus on your work with the California Endowment, which you headed for two years from 1998 to 2000, on the board of which you still sit. Can you tell us a little bit about the general scope of the work of the California Endowment?

A I can. And it was very interesting to me to hear the last witness, because I hadn't gotten a preview, and there's an interesting - very significant overlap in the purposes and plans that are going forward here and what we've been doing in California.

Basically our purpose clause is stated more simply, it's to provide access to affordable quality healthcare and related services to the underserved, uninsured and underinsured, and to improve the health status of all Californians. And I think that all of the catalog of needs

that are in the purpose clause that was up on the board are really subsumed under those things.

Right now we have a corpus of 3.4 billion dollars and we're making grants of about 170 million dollars a year in California. Our grant making is divided roughly 50/50 in two categories; one, responsive, and the other strategic. The responsive grant making is really very community based. It's our view that a lot of the health problems - solutions to health problems must come out of communities if they're truly going to be served in the long run. But I also heard the last witness talk about focus, and in our strategic side we have tried to focus on specific areas. Access, because it's in our purpose clause, is a big focus. And in access, we've been trying especially to see that people eligible for the federal Chip program and federal Medicaid program in California, which are called Healthy Families and MediCal, I don't really know what they're called here, but to see that people who are eligible get enrolled in those programs. We have a big focus on agricultural workers because they are a population of California that have one of the worst collection of health indicators of any population in the state. We've done a lot on work force development, and I'll mention that a little later with some slides.

Because California is a very diverse state, and we now have a minority-majority in the state, multi-cultural health

is important to us, and cultural competency in the health delivery system is an important issue for us.

And finally, just to give you some rounded off but not give you the whole catalog, we've been working on mental health, which we think is the sort of orphan in the healthcare system because - both because of the issues of availability of treatment and coverage, but also because of the stigmatization of mental health.

So we've organized on a regional basis with offices in five cities around the state, and we have differences within the state geographic, ethnic, economic, that are really quite similar to what I've been hearing in the hearing here the last couple of days. The differences between South Central LA and northeastern and rural areas of California are quite similar to what I'm hearing about the differences between Seattle and Eastern Washington.

So, we started with about three billion dollars. We have spent in grants and charitable purposes about a billion dollars in the last eight years. And even having gone through the worst bear market in 40 years, we're back to about 3.4 billion dollars today.

Q You said that you had operated through five regions, I believe. Has the work of the California Endowment reached to all of the counties in the state, and can you give us a sense of how many grants you've issued over this period of time?

A Yes. When I say we have five regional offices, we put program officers in the offices so - in each of the offices so that program officers are in direct contact with the community-based non-profits around the state. And we've - in this eight years we've made over 3,000 grants. And I don't have the number at my fingertip, but I would guess that - perhaps it would be better if I estimated rather than guessing - that there are probably 1500 individual grantees for those 3,000 grants.

Q Mr. Reid, I'm wondering if you could give us some examples of projects that you are familiar with from your work at the California Endowment, and by way of preface, let me ask you whether you have some slides that are gathered at Exhibit P-14 to illustrate your testimony?

A I'm told I do.

(Projector on.)

A The first slide is here to illustrate leverage in the philanthropic grant making. We were quite concerned early on about the plight of agricultural workers in California, and surveys and site visits made it very clear that a lot of ag workers were living in substandard, very unhealthy environments and that, as a public health matter, in order to improve the health in those communities it was going to be necessary to attack the problems of housing. We knew we didn't have enough money to do this, but the scheme that we

embarked on, and this was a grant to be made late in 1998 or early in '99, I can't remember the exact date, but it was probably January '99, was to a group called the Rural Community Action Corporation. And RCAC took a 20 million dollar interest-free loan and 11 million dollar grant, and under the guidance of a community-based advisory group that we put together, used those funds to make loans to communities for ag worker housing, but only if they combined the housing with health-related facilities. Which might have been a new clinic in the community, a commitment to deliver services at a community center, or new mobile health facilities, or even in one case I think they took a closed rural hospital and turned it into a community health center.

Over the life of that project, since early '99 through the end of 2003, I think something like 13 or 14 million of that 20 million dollar loan fund has been disbursed in loans to communities. And the miracle of leverage is that that money as seed money has enabled the communities to bring in private tax credit investment money and other private and governmental funds in the amount of the hundred million dollars that's shown on the chart, so that the leverage that we got on that money was about seven to one.

Then subsequently, because the program was so successful, the state has kicked in over 40 million dollars and supported the passage - successful passage of a bond

issue for 180 million dollars to address the problem. So, with really only 11 million of our money, irrevocably out of pocket, we've created an enormous impact. So, I apologize for spending so much time on that one. I know my time is limited.

Q Before you move on, you say at the end that there's been some evidence of improved health and environment in the funded communities, Mr. Reid. Can you tell us a little bit about that?

A Well, I - in terms of disease specific themselves, the most dramatic was in the reduction of asthma. In the evaluation of the project, in one of the neighborhoods, there were surveys of the residents before and after the project, and just the evaluation data here is the pre and post percentage of residents who were very or somewhat concerned about these items, dirt and garbage on the street, pre 89, post 11; noise or trouble from drunks, pre 81 percent, post seven percent; abuse and selling of drugs, pre 58 percent, post 11 percent; crime and vandalism against property, five - 50 percent before and four percent after; crimes against people, 59 percent pre, seven percent post. The whole nature of the communities where this project was piloted has changed.

The next project --

Q Which one do you want to talk about next?

A Well, that's fine. Just following on to that particular

project, it's now - that was early '99 and it's now 2004. Last year the California Endowment set aside 50 million dollars to improve the health of migrant workers. That was the consequence of a study that we did and published called Suffering in Silence. And it's really about what's the health status of the people who put the food on our tables. And as a consequence of that study, as I say, we set aside 50 million dollars to work on health of migrant workers. Probably one of the most interesting parts of that is working with the administration of Vicente Fox in Mexico to try to figure out ways to deal with the issues in transnational families where part of the family stays at home in Mexico and part of the family is moving back and forth across the border, and how the family gets healthcare.

The next project, which is one of my favorites, deals with the Native American population in California. We have up on the north coast, in Humboldt County, an organization called the United Indian Health Services. UIHS represents about 15,000 people, and it's nine different tribes and bands who come together to provide health services in their community.

Back in about '97 we gave them a planning grant to see what they could do to improve their facilities. Then in, I'm going to say early '99 we made a three and a half million dollar grant to them; two million outright and a million and

a half was a challenge or matching grant. And we gave them the money as the seed money to create a new state-of-the-art Indian health clinic. They bought 14 acres of land right on Highway 101. If you drive through Arcata and look to the west side of the highway, you'll see the beautiful building.

They used our money as seed money and went out and raised money from other foundations, including the Ford Foundation, they raised money from individual donors in the community, and they got commercial loans because they had enough equity to do so, and they built a fabulous new clinic, which is run by the Indian board of directors of the United Indian Health Services, and incorporates into the clinic all of the cultural activities of the tribes, and is really a place where there's focus of regeneration of the culture of the area. Which they believe and I believe is very important to health, because I don't think you can really separate the two issues. So, just a short list of a few other...

THE WITNESS: Is that close enough now?

COURT REPORTER: That's great, thank you.

A I'm sorry. We became concerned, and our sister foundation, the California Healthcare Foundation, was concerned about the issue of the wasteful use of emergency room facilities by frequent users who come to the emergency room always in a critical state because they haven't had access to the sort of preventative care or routine care that they should have. And

it - those few users have eaten up an enormous amount of the resources of some of the hospitals, especially the larger county public hospitals.

We had an example of a pilot study that had been done of 100 frequent users in one of the large public hospitals, actually AIDS patients. And the - by putting together a program that brought together case work and better coordination of all of the health and social services, there was a very, very dramatic drop in the usage of the emergency room and improvement in the health of the patients. So, we put 10 million dollars on the table to see if we can take that experience and create a more comprehensive pilot to possibly create a model for what the public hospitals throughout California might do in their emergency rooms.

Community clinics in the safety net are really very important to us and we've spent a lot of money on that; I say on the chart 60 million dollars. A large part of the money early on, there was a mention of the Y2K problem yesterday, the community clinics were surveyed, there are about 500 in California, and they and their trade association, the California Primary Care Association, came to us and said that their greatest need was IT, and within IT the cloud that was hanging over them was Y2K. And other potential funders were afraid to help them because the stories around at the time that anyone who invested in trying to solve the Y2K problem

might be held liable for the calamity that was about to come. So we put 20 million dollars into the community clinics around California to help them get their IT competence up, and subsequently began to give them seed money for training and capability to go out and raise capital funds so that they could improve the capital facilities of them.

I was interested in hearing the last presentation on the nursing shortages. We have the same problem in California, and in our efforts in work force development have focused in part on that. The area of the state that we focused on was the central valley, the rural central valley, where the numbers of nurses are half the national average per capita, and the availability of nursing staff that mirror the population ethnically is just dismal. So we put 10 million dollars into a program that's very similar to what I heard discussed just a few moments ago, a combination of building up the staffing and capability of the nursing programs in the valley, and scholarship programs to make nursing training available to young people.

Other things in the Native American population, we focused a lot on diabetes control, which is an epidemic problem in that population. And a unique telemedicine program that was conceived and executed by a brilliant young African American ophthalmologist in Los Angeles using facilities out of the University of California at Davis, near

Sacramento, and taking the expertise of the ophthalmologists from the city centers in California out to the rural Indian health centers. That's a part of our telemedicine initiatives. We spent a fair amount on trying to build the telemedicine infrastructure to get the expertise of specialists out to the rural areas where they're not otherwise available.

And I - the last bullet point, "Hundreds of small grants to community based," that's the other 2,990 grants which I think you probably would not bear with me if I tried to describe.

Q Based upon your experience, Mr. Reid, can you tell us what role philanthropy can play in addressing health needs, unmet health needs in states where there are foundations established such as the one you've been involved with?

A Well, I - I'd like to answer that by contrasting philanthropy and charity. One of the witnesses yesterday was asked what's the amount of uncompensated care at a particular hospital, and there was speculation, is it 25 million or is it 100 million. It's very clear to me, to consultants who filed reports for the OIC and the intervenors in this matter, and anyone who has experience in this system, that the gap in funding, whether it's a gap in the amount of money you'd need to buy insurance for people who are uninsured or to provide uncompensated - compensate for the uncompensated care, it is

just so big that the resources of this foundation or any foundation are really a drop in the bucket. So you can't engage all of your money in charity or it will be like taking a glass of water out to the beach and dumping it on the sand, it will just disappear.

What you have to do is engage in philanthropy. And the characteristics of that, in my mind, are, first you have to have a long horizon. You have to look not to the problems that are today's headlines, but to how you solve long-term systemic issues. And philanthropy is - foundations are in a unique place because they don't have an election coming in two years, and they're not on a budget cycle that's going to come up where they have to decide whether they've got a profit for that year. So they have the capability, as other institutions don't, to take a long view.

Philanthropy foundations can take risks because they're really uniquely suited to take risks and undertake projects that may fail. They can do pilot projects that, if they're successful, may be replicated in other places and with other sources of funding to really make fundamental change. And I discovered yesterday that one of the later witnesses in this hearing is going to talk about a project that our sister foundation, the California Healthcare Foundation, funded in Santa Barbara County, California, which the people are now saying may save billions of dollars nationally.

The foundations can engage in data collection and dissemination because one of the techniques for taking rhetoric and ideology out of the discussion of the healthcare system is facts. And if we can gather data and get the data disseminated and get an agreement about what the facts are, we'll be much closer to having a solution. And I think it's generally accepted now that most of the uninsured come from working families. And five years ago, 10 years ago, one would not have expected that. But it was data collection and dissemination that created that reality for us so that we can go forward.

Health policy research is very, very important, and I think one of the witnesses in this, a Professor Katz, talked about the funding that he's received from foundations. There's a cadre, a profession of health policy experts around the country who are funded by foundations such as the Kaiser Family Foundation, the Commonwealth Fund in New York, the California Healthcare Foundation in California, and without foundation funding, that profession would shrivel and the forward thinking about health policy initiatives would also be harmed.

I've talked about the leverage. One final tool of philanthropy that's important, and Gordon Conway, who is the president of the Rockefeller Foundation, believes that this is the single most important characteristic of foundations,

is their capacity to convene government, private interests, disparate interests, bring them together and cause them to work together to solve problems. So, those are the kinds of things that - tools that foundations can use, or capabilities that they can use in solving problems. So when people say there's not enough money in this foundation or won't be enough money in this foundation to pay for the insurance for all the people who are uninsured, I think it represents a misconception of the role of foundations in society.

Q Mr. Reid, you've described a number of projects that the California Endowment has carried out with its three-plus billion dollars of funds. I don't think we're talking about anywhere close to that amount of money here. So is there a reason that you believe that the experience that you've had that you related to us might have some bearing on the issues before the commission?

A Yes. And I mentioned this in my first report. Shortly after I took on the job as the CEO of the California Endowment, I went back to New Jersey to sit at the feet of Dr. Steven Schroeder, who at the time was the head of The Robert Wood Johnson Foundation. So Schroeder is sitting there on an eight billion dollar corpus and I went to get ideas from him about what we should be doing. Interestingly, their purpose clause that - their mission and access and health status is very similar, almost identical to ours and the California

Endowment, and really tracks with what - with what's been developed here. And Schroeder said, I envy you, Lew. He said, I have eight billion dollars but I have to spend it all over the country, and you have three billion dollars but you only have to spend it in California, and on a per capita basis you can have much more impact than The Robert Wood Johnson Foundation will ever have in your area. And so when I became involved in this project, I got a pencil out and tried to see what was going to happen here, and to my surprise the impact per capita of this conversion would be of the same order of magnitude as the impact of the conversion of Blue Cross of California.

So I think that if the conversion is approved and goes forward, the experience here could very well be quite similar to the experience that we've had in California.

Q Mr. Reid, based upon your experience in having done so much of the planning for the creation of the California Endowment and the California Foundation, do you have an opinion about the nonprofit tax planning that's gone into this particular proposal?

A Yes, I wrote a lot about that in my original report. And I started my life in this conversion arena as a tax key (phonetic), and I won't repeat everything that's in the report, only to say that I think you've made the right choice here in using two 501(c)(4) organizations, for two reasons.

It minimizes the amount of potential charitable funds which will be drained off to pay taxes, and it also gives you the transactional flexibility to handle the sale of the stock and the other transactional details in a way that I believe will maximize the value of the proceeds of the stock.

Q Mr. Reid, in your opinion, do the requirements and restrictions that have been placed on the foundations with respect to the stock that they are to receive from Premera diminish the value of that stock?

A Well, would it be a distraction if I answered?

Q Please go ahead.

A I don't think they do. What you will have here is the conversion of a business that operates with a license from the Blue Cross and Blue Shield Association. And I think it's - everyone in the room will stipulate that that license has great value and if the license were lost, the value of the business would be diminished.

The restrictions which are required to be included in the transaction in order to preserve the license are, as I see it, part of the business. You can't take them away. You can't take the restrictions on voting and the restrictions on divestiture of the stock away and say the business has a value and those things diminish the value. The business is a whole. You can't unscramble the egg and only eat the parts you like. It's really important to recognize that all of it

is a part of the business.

Now, some have said that those diminish the value of the stock in the hands of the charities. I'm not persuaded that's true. If I were a stockholder, a potential investor, I wonder how I would feel about investing in a company that's owned largely by a charitable foundation with a mission to improve access to healthcare, with no - with total voting rights and with no obligation to divest the shares. So you have - you have no knowledge about when shares are going to come on the market. You have no knowledge about whether that shareholder is going to manage the business to the benefit of the business or to the benefit of the charitable mission of the shareholder. And if the board of directors has been chosen in the way that I devoutly think it should be, the board of directors is not going - of the charity, is not going to be the appropriate board of directors to be holding the majority of the stock of a functioning business.

So that's not the kind of a business that I think I would want to put my money in. And I suspect that others would hold that view. So, that's my view. I don't know if I'm right because I can't quantify, if you did unscramble the egg and pick pieces out, what would increase or decrease the value. But I suspect that those restrictions may in fact increase the value of the business.

The IRS took a similar view in the legislative history

of the provision that prevents private foundations from owning control of businesses, such as 49.43, the Access Business Holdings Rule. And in that legislative history, you'll see the concerns that Congress and the IRS had about foundations tending to the foundation business and not trying to run business corporations.

So, I think I cannot say that the restrictions that require divestiture or that limit voting rights in this transition, hopefully brief, between a nonprofit but no shareholders and a for-profit stock corporation listed on the New York Stock Exchange with no controlling shareholders, that those restrictions are going to hurt the value of the stock and the value of the charitable endowment that will result from the sale of the stock.

I can tell you that in California we had a much more restrictive divestiture schedule and the stock was sold easily within five years, at good values, it was in a market that was good, because it was '96 to the year 2000. But there was no problem getting the stock sold. And I believe that those restrictions didn't in any way diminish the amount that went to charity.

Q Mr. Reid, in your judgment, does this transaction that's been proposed serve the public interest, and if so, how?

A Well, I can't speak to the insurance business side of this. I don't have the expertise to acknowledge that at all, so I

have to leave that to everybody else. All I can speak to is the foundation side. But as you will have figured out, I'm passionate about the value of foundations to society and, as I heard the numbers this morning, this will increase almost by an order of magnitude the amount of philanthropic funds available for health charity in the state of Washington. I believe it will fund the work of many hundreds of community-based organizations around this state if it's directed in the proper direction. And I think it's an opportunity that would be tragic to lose.

Q Thank you. I have no more questions.

JUDGE FINKLE: Let's take a morning break. We'll see you in 15 minutes.

(Recess taken.)

JUDGE FINKLE: Ready to presume?

MR. MITCHELL: Yes. Your Honor, I neglected before the break to ask for the admission of Exhibit P-14, which are the slides that Mr. Reid used in his testimony.

JUDGE FINKLE: Any objection?

MS. deLEON: No, Your Honor.

MS. HAMBURGER: I'm sorry?

JUDGE FINKLE: The slides used in the testimony are P-14. Any objection to those?

MS. HAMBURGER: No objection.

JUDGE FINKLE: Admitted.

(Exhibit P-14 admitted.)

Q (By Mr. Mitchell) The other thing I neglected to do was to get the slides up all the way that we were talking to in your testimony, Mr. Reid, about the relative size of the healthcare foundation.

(Projector on.)

All right. We've gone through The Robert Wood Johnson Foundation, I think, and we got through the California Endowments. Can you then draw the comparison that the slide was meant to illustrate, Mr. Reid?

A The - what it was intended to illustrate was that RWJ, which has roughly eight billion dollars, if divided by the population of the United States, comes out to about $28 per person. And then if you divide the populations of California and the combined population of Washington and Alaska by the, in the case of California, into a three billion dollar corpus, you've got $87 per capita. And in Washington and Alaska, I - for the comparison on the slide, it's just the mid point between Blackstone's 500 and 700 million dollar range. Obviously the actual number is not important. The point of it is that you're at the same order of magnitude here that we were in California with the creation of the California Endowment. So that in terms of what can be done for the population here, the experience should be able to be roughly the same. Unless the money is drained off in other

purposes, non-philanthropic purposes, such as, for example, the New York experience where the money was all spent for three years of wage raises and the money now is gone.

Q Thank you. I have no more questions.

CROSS-EXAMINATION

BY MS. deLEON:

Q Good morning, Mr. Reid.

A Good morning.

Q You just showed a slide here that talked about what the Washington endowment would entail and you have 600 million dollars up there; is that correct?

A Yes.

Q Exactly where did you get that number?

A The OIC consultants, Blackstone, had a range in one of their reports of 500 million to 700 million. So we just took the mid point, 600 million, and divided that by the population of the states. In the U.S. Census I believe - I believe it was the 2001 number that was the most recent number that I could find when I did this initially in preparing my initial report.

Q Was it your understanding that this was a valuation performed by Blackstone?

A That was my understanding. I don't know whether - just to make it clear, I don't know whether 300 million or 600 million or 900 million or a billion is the number. I have no knowledge of that and I was not endorsing a number. I was just trying to find a number so that I could do a back-of-the-envelope calculation to see if there was relative similarity in the potential impact here in California.

Q Isn't it true though under the terms of this conversion we really won't know the value until the stock is sold?

A That's right.

Q So it could be something much less than that or something much higher; is that correct?

A That's correct.

Q Now, when you sold the stock in - or the stock was sold in the California conversion, that was back in around 1996; is that correct?

A The conversion occurred on May 20th, 1996.

Q And at that point how long after that was the stock sold?

A Well, it was somewhat different because, as you know, the non-Blue businesses had been dropped into a wholly-owned subsidiary in '93, that subsidiary was named WellPoint. And WellPoint was taken public, and 19-plus percent of its stock was sold to the public for a little less than a half a billion dollars. So, WellPoint was already a public company when the conversion occurred. The stock of the converted

Blue Cross was sold by the California Healthcare Foundation over a period of four or five years.

Q Did that commence in 1996 or end of 1996?

A Oh, it commenced in 1996.

Q Isn't it true that the stock market back in the late '90s is way different than the stock market is today?

A Well, the stock market every day is different than it was the day before. The stock market, as I said earlier in my direct testimony, was very favorable at the time. I don't know that any year during that period of time was better than the market was last year, and I don't know what the market is going to be next year. But I, in my own personal affairs, I'm predicting that we will not have another 40-year bear market in the immediate future. So I'm optimistic about the ability to monetize stock after this. But you're absolutely right, there's no promise.

Q You talked a little bit before the break about being an investor and your opinion as an investor on the restrictions of the stock, that it wouldn't prohibit you from buying the stock. Is that correct?

A I think what I said was that if the bulk of the stock of the company were owned by a charitable foundation, with the kind of mission statement that this one has and the kind of board of directors that I think it should have, that with no assurance that there would be a timely divestiture, then I'd

be very worried about whether the business would be aligned to serve the charitable mission or a business mission, and it would - and how long the overhang would exist. So, it seemed to me that it was quite likely that the existence of restrictions which prevent the charitable mission from leaking over and influencing the operations of the business and assure an orderly transformation of the company into a widely-held public company would make the stock more attractive rather than less attractive to investors.

Q But this is all speculative on your part, is it not?

A It's my opinion.

Q Do you know of any studies that have been done regarding this issue?

A No.

Q Do you know what the limitations are of the foundation directors currently in the bylaws of the Washington Foundation shareholders?

A I know there are some there but you'll have to refresh my recollection.

Q But you talked about the limitations on the board - limitations of the board of directors?

A What I was - I wasn't talking about limitations. What I was - what I was saying, although not very clearly, I guess, I believe that this board of directors should be a very widely based - broad-based board of directors representing all

segments of the Washington society. And I don't think it should be a heavy-duty corporate board elected from the elite of the business world. I think it should have representatives from community-based organizations, from different ethnic groups. And if you are choosing a board to broadly represent society rather than run a business, you may not - and a board that is directing an organization with a social purpose mission, what I was saying is that there would be some concern about that leaking over into the operations of the business.

Q Okay. In your direct testimony, Mr. Reid, on page five, you talk about there's been a burst of new health philanthropy in the United States; is that correct?

A Yes.

Q Wouldn't you agree that there are still many unmet healthcare needs and these continue to exist, and they've even grown?

A I know there are many unmet healthcare needs. You would have to be more explicit before I could say - you tell me what they are, and we can talk about whether they have grown.

Q Well, you said that there's been a burst of health philanthropy, but yet there are still many unmet needs out there?

A Yes, there are.

Q Okay. The California Endowment that you speak of awards grants and monies to non-healthcare-related issues, does it

not?

A No.

Q To your knowledge, they've never given monies or grants to anything other than to meet healthcare needs?

A Well, let's be careful about the words. Healthcare may be interpreted by some to relate to the healthcare delivery system. The proposed Articles of Incorporation of the Washington Foundation refer to meeting the health needs of the people of Washington.

If you talk about healthcare, some people would say that you have to eliminate prevention, public health issues, environmental issues. So, you - so you have to be aware of what word you're using. I think the California Endowment is quite careful to see that the grant making that it does is directed at either improving access to healthcare and related services or improving the health status of all Californians.

Q Can you define health status?

A Well, I think - you look at community indicators of health. For example, let's talk about obesity. Childhood obesity is one of the things that the California Endowment is trying to get a handle on right now. And that's almost certainly not going to be dealt with through the mobilization of the healthcare delivery system. If we can get a handle on that problem and reduce childhood obesity, it will probably be through public awareness campaigns, things that influence

diet, and they won't be healthcare. But if we're successful in creating models that can address that problem, it will undoubtedly improve the health status of the community because it will lead, for example, to less childhood diabetes, less adult heart disease.

Q Does the California Endowment ever provide funds for disaster relief or anything like that, to your knowledge?

A Yes.

Q Could you describe some of those?

A Well, I know we have provided food assistance after disasters. Disasters have been fires and floods. And in those people are displaced from their homes and lose their assets. So we've provided money to relief agencies which help during those times.

Q And how does that fall within the mission of the California Endowment?

A Well, I think the survivors of disasters are at risk for their health, and I don't have any problem at all providing money to community-based organizations to assist the victims of disasters.

Q On page six of your testimony, Mr. Reid, you talk about a laundry list of some examples of needs --

A Could you help me with where that --

Q Page six.

A Of the original report?

Q It's not of your report, sir. It's of your direct testimony, pre-filed direct testimony. Exhibit P-8.

MR. MITCHELL: It's the first document, I think, Lew.

A Okay.

Q (By Ms. deLeon) There are several bullet points on this page regarding issues. The first one is, says, "Millions of our residents are uninsured." I'm assuming that you mean California residents?

A Yes.

Q And are more people insured now as a result of the California Endowment?

A I think the number is something on the order of seven million dollars, and I believe the biggest group of the uninsured are people eligible for federally funded programs who are not enrolled. We've been engaged, as have all of the health foundations in California, in serious efforts to try to get people enrolled in those programs. As the population grows, I can't tell you what the impact of the endowment's programs have been. It is a polycentric problem, and you cannot analyze it in a way which will give you any comfort that the efforts of a particular agency are reflected in the outcomes. It's one of the frustrations about some aspects of philanthropy, is that you find it very difficult to assure yourself that your work has had the desired effect.

Q Mr. Reid, on page 13 of the same exhibit, line 19, there's a sentence that says, "However, if the amount realized by the Health Foundations were to be in the range of $500 million to $600 million, the amount per capita available to health philanthropy in Washington and Alaska would be roughly equivalent to that available in California from the California Endowment." And it goes on. The word "if" is in that sentence. What do you envision as the risks to the conversion utilizing the 500 to 600 million?

A I have no idea. I've never looked at a financial statement of Premera and I don't know that, not being an investment banker, I would have the capability even if I looked at it to make an informed estimate of what the value would be. So I - in taking that number, as I said, I was trying to extract a number that some of the other experts had provided, and then say, if - the purpose of the if was to disclose my lack of expertise in setting the number.

Q Thanks. On the next page, right around line 15, I'll read the entire sentence. You say, "The structure of the Proposed Transaction will maximize the potential economic benefit to charities by providing transactional flexibility and by minimizing the taxes incurred in the process of realizing the value of the initial stock of New Premera issued to the Health Foundations." What do you mean by "transactional flexibility"?

A Well, the - under section 49.42 of the Internal Revenue Code, New Premera will be treated as a substantial contributor to the Washington Foundation. As a substantial contributor, it will be a disqualified person. There are a number of types of transactions which may not occur between a disqualified person and a private foundation. If the Washington Foundation were organized as a 501(c)(3) private foundation, those restrictions would apply. There are a number of provisions of the Registration Rights Agreement and the transfer of Grant and Loan Agreement which could be affected by section 49.41. Did I say 49.42? The correct number is 49.41 of the code. And those involve various options, fee sharing arrangements, the promissory notes, and the Option Loan Agreement. You sidestep all of those transactional difficulties and increase the flexibility in the sale of stock by using a 501(c)(4) organization.

Q So it's a good thing, then --

A Yes.

Q Okay.

A Using the 501(c)(4) avoids transactional constraints, which I believe could reduce the sales flexibility and ability to maximize the sale proceeds if you used a 501(c)(3) private foundation. And that's - in California that's the sole reason that we ended up - or not the sole reason but that's one of the reasons that we ended up creating the California

Healthcare Foundation as a 501(c)(4) organization.

Q On the next page, page 15, under the first answer, you say, "The single-tier structure proposed in the Amended Form A, as contrasted with the two-tier structure in the original Form A filing, introduces some additional complexity in the relations between interests in the states of Alaska and Washington." What are those additional complexities that you refer to?

A Well, we see a difficulty in deciding on an allocation of the stock between the two states. The - that is moved forward in time because that really either has to be resolved before the closing or you have this excess shares --

Q Unallocated?

A -- unallocated shares escrow agreement, which is an awkward kind of a document. I think having a single foundation shareholder would have been simpler, but I gather that you're well beyond that and everyone has accepted the additional complexity.

Q You go on to say that "It also introduces some additional uncertainty in the ability of the Washington Foundation to be recognized as a section 501(c)(4) entity." What's the uncertainty?

A Well, the uncertainty is detailed at some length in some of my papers, at greater length in the papers that Mr. Lundy has filed as an OIC consultant. He's the expert from

PricewaterhouseCoopers. In the original plan you unbundled the function of monetizing the stock and performing the charitable missions. In this case you put them together. Mixing the charitable mission into the function of the - mixing the charitable mission and the monetization together in the Washington Foundation makes it look much more like a typical 501(c)(3) organization. And what Mr. Lundy has said is that that raises some risk that the IRS will say no, we're not going to recognize this as a (c)(4), we'll recognize it as a (c)(3). And I think that would not be a good thing.

Q Why?

A Because it would - as we talked about just a minute ago on the prior page, it would increase the taxes that would have to be paid and it would place certain constraints on your flexibility and the disposition of the shares. But I don't think there's any change that you need to make to deal with that. You can't dodge it. You just have to deal with the issue as and when it comes up at the IRS.

Q You go on to say, down on line 15, that "The independence of the Washington Foundation for New Premera in the Amended Form A proposal should alleviate prior expressed concerns about New Premera control"; is that correct?

A Yes.

Q But New Premera has put a lot of restrictions on the Washington Foundation; isn't that correct?

A Which restrictions are you referring to?
Q Well, they've told the Washington Foundation basically when they can sell the stock, the divestiture schedule. They've told the Washington Foundation - or given them certain requirements as to who can be on the foundation's board. They've also told the foundation that New Premera can veto all of the three nominees that the foundation shareholder provides to them as a designated board member. Isn't that quite a lot of control?
A Let me - I'm sorry, I didn't write those down, there were three of them. What was the first?
Q The divestiture schedule dictates the time frame.
A What was the second?
Q The qualifications or who can be on the foundation shareholder board.
A Right.
Q The - Premera can veto all three of the nominees for the designated board member. And those are just three of a laundry list.
A Okay. Let me take those separately, because I think - I think they raise different issues. I think the divestiture schedule is really critical to the welfare of the foundations and to the creation of a healthy public market in this stock.
Q Why?
A The OIC's experts and others involved in the transaction have

urged that you have a desegregated schedule --
Q Could you - I don't understand what desegregated means.
A That each foundation have its own divestiture schedule and each being permitted to comply separately with the 80-percent, 50-percent, 20-percent, five-percent timetable.
Q Right. Instead of being Siamese twins, connected?
A Right. This is a place where I differ from Premera because Premera has adopted that position before the BCBSA. But I think that the consequence of doing that would be, let's assume that the allocation of the stock is 80 percent/20 percent, 80 percent to Washington and 20 percent to Alaska, which is somewhere between the highest number that you have suggested and the lowest that they've suggested. If you do that, and Alaska starts with 20 percent and Washington starts with 80 percent, there would be no - and you have two separate schedules for divestiture, there would be no obligation on Alaska to sell any stock for five years.
Q That would mean the foundation would have no money, wouldn't it?
A Bear with me.
Q Okay.
A If you take - if you take your argument to its logical conclusion, you would come to the conclusion that the divestiture schedules don't harm anybody because they'd do it anyway. So Alaska would have no obligation to sell for five

years. Washington starts with 80 percent, it has no obligation to sell in the first year because it's already at the 80-percent mark. And at the three-year mark, they'd have an obligation to sell down to 50 percent, so they'd have to sell 30 percent of the stock. So three years out, three years after the IPO, it's conceivable that 70 percent of the stock could still be held by the charitable foundations. I think that kind of an overhang on the market could very well have a very depressing effect on the market and the stock, and could seriously affect the - seriously and adversely affect the value of the charitable endowments.

So, I don't see the divestiture schedule as a disadvantage, nor do I see it as a restriction imposed by Premera. What I see it as is a condition that Premera must meet if they want to retain their valuable Blue Cross/Blue Shield Association license.

Qualifications of the board members, your second point. I see this as a different issue, and I come to it from the standpoint of having been through several conversions that have taken different models in terms of forming the board. But in California, the Blue Cross/Blue Shield Association demanded that the foundation boards have former Blue Cross board members on them. And the arrangement that was finally reached was that a minority of the board of the non-stockholding foundation, the California Healthcare

Foundation that I ran, had nine former Blue directors and 11 of new non-Blue directors. The California Healthcare Foundation was required to maintain a majority of former Blue directors until they had divested the stock.

So if you look at this as the converting company and you're putting, in that case three billion dollars, in this case if there is 500 million, 600 million dollars, you're putting this big pot of money out there as a potential social force in your community, and is there a risk that it's going to turn around and bite your business? Well, maybe so. So restrictions by the don't-know-her, in this case, come from a very different place than Blue Cross was in California, where they knew the former Blue directors were going to control the board for five years or more.

In New York, for example, there was no incentive to have something of this sort because the money was going out the door to pay wages, it wasn't going to be a lasting social force in the community. So, I can understand the potential motivation. And this is speculation on my part because I have not talked to Premera about why those are in there, but I can understand how if I were in their shoes I would want some protection against the possibility that the foundation would be utilized to damage the business that it came from.

Q But Mr. Reid --

MR. MITCHELL: Let me just ask if the witness has

finished his answer.

THE WITNESS: Yes.

A I want to get on to your third point.

Q (By Ms. deLeon) Well, I want to talk about this point just for a second before we move on.

A Sure.

Q That's sort of illogical to me because the foundation, until all of the stock is sold, relies on getting the money from value of the Premera stock. So why would it bite the business if its money that it was getting was dependent upon how well Premera was doing and the stock price?

A Might not.

The final point on the veto, it seems to me that shareholders elect directors, and that the directors of New Premera will have a fiduciary duty to all of the shareholders of the company in the nomination of directors. So I don't see the ability to veto candidates put forward by the foundations as unusual or objectionable.

I also suspect, and this comes out of my own experience, the - the view of these transactions in all of them that I've gone through is different whether you're looking through the glass before the transaction and what it might be after or you're looking through the glass after the transaction about how could we ever have been worried about that. And it's my belief from my own experience that the foundations will do a

responsible job in selecting candidates, and that the company will do a responsible job in assessing those candidates. I think at this stage of the process it's quite natural to have a fear about what might be, but having seen several of them with what turned out to be, I'd have a lot of confidence in - especially with the processes that have been set up and the attorney general's involvement in the selection of the board and the kind of staff work that's been done already, I - I'm not worried about those problems.

Q You think it's much ado about nothing, basically?

A Frankly.

Q Moving on to page 17, Mr. Reid, on line 12, you state that "The BCBSA restrictions, although they limit the rights of shareholders in material respects, are ultimately in the interest of all parties." What do you mean by "material respects"?

A Well, the voting trust limits the voting rights of the foundations.

Q But they're ultimately in the interest of all parties?

A I believe so.

Q Why?

A Well, what you have is not - this conversion, if it's approved, is not something that happens one day and there's a seed change and everything in the future stays the same. This is a process. And it is a process by which you take a

nonprofit corporation that doesn't have any shareholders, no outside control, and you move it to a state sometime later in which it is a widely-held public company with no controlling shareholders, no institutions will have more than 10 percent, no individuals more than five percent, and no groups will be aggregated to exceed those limits.

Well, in the middle you have the anomaly of two shareholders who own 100 percent of the stock. And I believe that limiting the voting rights is important to prevent that anomaly from derailing the smooth process from nonprofit to widely held for public corporation without controlling shareholders.

MS. deLEON: I have no other questions.

CROSS-EXAMINATION

BY MS. HAMBURGER:

Q Good morning, Mr. Reid.

You testified just before about how the former board members from Blue Cross of California were on the two conversion foundations. Post conversion; is that right?

A That's correct.

Q But those board members had a fiduciary duty to fulfill the obligations that they had as being board members of those

foundations?

A That's right.

Q And that they had that fiduciary duty to fulfill the purposes of the foundations?

A That's correct.

Q Now, the - neither foundation has shied away from grants that WellPoint might not like?

A You know, I - first, I'd like to go back a minute because there was some testimony earlier, one of the earlier witnesses said that they thought that maybe having a Premera director on the board would be a conflict of interest. I know that's not going to happen here, but I don't agree with that, and from my own experience I think it probably would not hurt and would probably be a good thing if there were Premera representatives on the board. But that's neither here nor there because it's not going to happen.

But specifically what will --

MS. HAMBURGER: I'm sorry, I'd like to object to that and move to strike it as nonresponsive.

JUDGE FINKLE: Denied.

A But go ahead and tell me your question again, I'm sorry.

Q (By Ms. Hamburger) My question is, the California Endowment has not voided grants that WellPoint may not like; is that correct?

A I was hesitating because I was trying to think. I can't

remember an instance in which that issue has even been raised.

Q So it's never come up that a concern - that WellPoint might not like a grant that the California Endowment seeks to make?

A No.

Q Are you familiar with the Health Rights Hotline?

A If that's the one that's ran out of Pecoima.

Q It's run out of I think Sacramento.

A Oh, yes. Phil Lee's son runs it.

Q Mm-hmm. And is that a program that's funded by the California Endowment?

A Yes, it is.

Q And it provides managed-care consumers with information about their rights when they have disputes with health plans; is that right?

A Among other things.

Q And it provides advocacy to consumers when they have disputes with their health plans; is that right?

A That's right. That was one I was skeptical about funding because it was being done through a legal services organization and I thought that it was just funding class action lawsuits, but then I visited and saw the work that they're doing and it's a really interesting project because they - with the variety of languages that we have in California and the people who are subscribers, not only in

HMOs but also public programs, there are real difficulties in the consumers being able to understand the plans and get their benefits. So, the hotline takes calls in many languages and resolves problems on behalf of the subscribers. And then they also have developed an incredible data bank of what kinds of problems are being raised, and they fed that data bank back into the county health departments and have been able to change the functioning of the county health departments in ways that address the specific problems that consumers are having. It's a very exciting program.

Q Mr. Reid, I'd just - I appreciate that information. As you may know we're on a time clock here, and so I have a number of questions to get to. I'd appreciate it if we could just kind of focus on the questions that I'm asking.

A Well, you just happened to hit one of my hot buttons about something that I'm very excited about.

Q I'm glad you're excited about the Health Rights Hotline.

In your report, Mr. Reid, you cited to a consumers union handbook called Building Strong Foundations?

A Yes.

Q And it contains some useful information, does it not?

A Yes.

Q In particular you cited it for the proposition that a wide-ranging search be initiated for the board of the new foundation?

A Yes.
Q You testified that you also understand that Premera has a series of meetings with stakeholders and community groups to hear what needs are most critical in the states of Washington and Alaska?
A Yes, although I learned more about that this morning than I had known earlier.
Q Those meetings are not a substitute for the public diverse wide-ranging and non-bias process you described in your testimony for board selection, is it?
A No, I don't think so. I think what we did in California was have eight community meetings around the state to elicit views on what problems were. And I would expect that in the process going forward the attorney general or the interim second board of the foundation will probably do the same thing.
Q Now, you testified that there's the two California Foundations, one is the California Healthcare Foundation?
A Right.
Q And you were a lawyer to both of them in the beginning?
A That's correct.
Q And that is the one that designated an IRS (c)(4) foundation?
A That's correct.
Q Now, that foundation has in its Articles of Incorporation and Bylaws certain restrictions that make it look similar to an

IRC - IRS 501(c)(3) foundation?

A Right.

Q In particular, it has a minimum five-percent annual grant-making requirement?

A Right.

Q And it is prohibitive from doing more than insubstantial lobbying?

A I believe you.

Q Are you saying that you don't know whether that's one of the requirements that - from when you were --

A As I sit here today, I don't remember, but I believe you.

Q Okay. And despite these restrictions, the California Healthcare Foundation obtained its 501(c)(4) status?

A That's correct.

Q Now, there was no limitation on either foundations' Articles of Incorporation or Bylaws that prevented a member of a medical association or a hospital association from participating in the board, was there?

A No.

Q And both - neither foundation can lobby for something that's in the interest of WellPoint?

A Well, if there's a restriction on lobbying I would - let me think about that. Assuming you're right, that the restriction says that there can't be substantial lobbying for an organization that large, the IRS safe harbor on lobbying

would be five percent of their expenditures. So, I presume they could lobby on behalf of WellPoint but for the private inurement restrictions.

Q So you don't recall if there's a prohibition against that?

A I don't.

Q And neither foundation has a prohibition against it that says it cannot fund activities that are materially adverse to the interest of health insurers?

A No, there's nothing like that in the articles.

Q And there was no agreement --

A Excuse me. I may have misunderstood your prior question that I gave a convoluted answer to, where you mentioned WellPoint. Could you give me that question again? Because I may have misunderstood.

Q Neither foundation has a - neither foundation can lobby for something that's in the interest of WellPoint?

A My answer stands.

Q Okay. Now, there was no agreement between WellPoint and either of the foundations that would permit WellPoint to sue the foundations or the grantees if it believed that the activities or that of the grantees was materially adverse to the interest of health insurers?

A That's correct.

Q In California, before the conversion occurred, no health impact study was done to determine whether the conversion

would have an impact on California consumers, was there?

A I don't know. I know McKenzie and Company did an enormous amount of work building up to it, but I - I don't know the answer to your question.

Q And McKenzie and Company are the people who are involved in the search for the foundation board?

A No. The foundation board was a search conducted by a consortium of search companies to represent various ethnic groups and communities around this state. McKenzie and Company is the management consultant company.

Q Okay. So there was no evaluation done of whether the impact of the conversion was addressed by the foundations grant making, was there?

A I'm sorry, I don't understand your question.

Q Okay. My question is, you stated just before that to your knowledge there was no health impact study done to determine whether the Blue Cross of California had - conversion had an impact on California consumers?

MR. MITCHELL: Object. It misstates prior testimony.

JUDGE FINKLE: Sustained. You can ask that question again, if you wish.

Q (By Ms. Hamburger) Okay, I'll ask that question again.

No health impact study was done to determine whether the Blue Cross of California conversion had an impact on

California consumers, was there?

A I don't know.

Q And so, do you know whether any evaluation of the impact of the conversion - whether there's been any evaluation on how the impact of the conversion is addressed by the foundations?

A I don't know.

Q Now, in your report you write that the conversion will unlock the charitable potential of the assets held by Premera.

A Yes.

Q Is that right?

But you haven't studied how the public currently benefits from Premera's nonprofit services.

A That's correct. Except that I heard this morning that there's about a half a million dollars in charitable grant giving at the current time, and the income from the - from a five, six, 700 million dollar endowment would permit charitable activities that are an order of magnitude bigger than that.

Q And - but you didn't do any of that research or study as part of your report?

A No.

Q So, in your report you did not evaluate whether the benefits from a foundation are sufficient to overcome the loss of Premera's nonprofit activities?

A No. As I said earlier, I really don't know anything about

the insurance business and the economics of the insurance industry. So, all I really can speak to is the foundations and what the foundations do and the structure of conversions.

Q Well, I appreciate that. It does seem a little - if I can refer you now to your supplemental report of page 17. You state that the Blue Cross/Blue Shield Association changed its licensure rules for conversion to allow more level, competitive playing fields so that Blue plans could compete with their non-Blue competitors. Do you recall writing that?

A Yes.

MR. MITCHELL: Excuse me, Counsel, can you point to the language you're quoting?

MS. HAMBURGER: This is in the second full paragraph, first sentence. Excuse me, the second sentence.

MR. MITCHELL: I don't believe that you quoted it accurately.

MS. HAMBURGER: I didn't say that I was quoting it, but Mr. Reid seemed to understand the question and answered it.

JUDGE FINKLE: Go ahead, please.

A Could you repeat that question?

Q (By Ms. Hamburger) You wrote that Blue Cross/Blue Shield Association changed its licensure rules for conversion to allow a, quote, more level competitive playing field, closed quote, so that the Blue plans could compete with their

non-Blue competitors. Is that right?

A Well, as I look at it now, and with this interruption, I - just so they could have the same access to capital as their non-Blue competitors.

Q But you do state that they - the change in the rules was to provide a more level, competitive playing field?

A Yes.

Q Do you know that Premera's two biggest competitors in Washington State are Regence and Group Health?

A I don't know anything about the insurance market in Washington.

Q Okay. You testified in your deposition that you've not looked extensively at other recent conversions; is that correct?

A That's correct.

Q And you haven't worked on Blue conversions in other states, other than in California --

A No, I have not.

Q Okay. You're not an expert on Washington nonprofit law?

A No.

Q You testified at your deposition that you reviewed the Articles of Incorporation of Premera and Premera Blue Cross?

A That's correct.

Q But you did not review the Articles of Incorporation and Bylaws of the predecessor organizations to Premera and

Premera Blue Cross?

A I'm not sure about that.

Q Did you, for instance, review the Articles of Incorporation of the Medical Services Corporation, Spokane County?

A I don't believe so.

Q Did you review the Articles of Incorporation of Blue Cross of Washington and Alaska?

A I don't believe so.

Q Or any of their predecessor organizations?

A I don't believe so.

Q So your determination that Premera and Premera Blue Cross does not hold some or all of its assets in charitable trust is not based on the - a review of those predecessor organizations, corporate charters, and Articles of Incorporation and Bylaws?

A No, I was looking at the parent corporations.

Q Now, on page three of your direct testimony, your pre-filed direct testimony, line 15, you state that when you say the conversion transaction is in the public interest, you say, quote, "I am speaking from the standpoint of the potential charitable beneficiaries"?

A That's correct.

Q You don't live in Washington or Alaska, do you?

A No.

Q And your testimony reports don't include any specifics about

the healthcare problems in Washington or Alaska?

A No, that's right.

Q And you've never been a beneficiary of a healthcare grant in Washington or Alaska?

A That's correct.

Q Your reports weren't based on interviews involving healthcare consumers or grantees in Washington State?

A That's correct.

Q You are aware that many Washington consumer organizations oppose the conversion?

A Yes, and it puzzles me.

Q You are aware that the - are you aware that the overwhelming number of comments received by the insurance commissioner from Washington residents oppose the conversion?

A No, I'm not.

Q Now, you testified that you represented a health insurance company, Blue Cross of California, in its conversion?

A That's correct.

Q And that conversion involved what you described as a controversy in your deposition.

A Can we look at that part of my deposition?

Q Sure, that's in your deposition line - page 20. I'd be happy to provide it to you.

MS. HAMBURGER: May I approach the witness to provide this line of his deposition?

JUDGE FINKLE: Yes, but I may need to see it as well. If there's no controversy, go ahead and provide it.

MR. MITCHELL: No pun intended?

JUDGE FINKLE: No pun...

A Ms. Hamburger, since this is the bottom of the page, could I see the top of the next page too?

Q (By Ms. Hamburger) Sure. (Handing document to witness.)

A Okay.

Q Okay. The conversion was involved - was a controversy; is that right?

A Well, you asked the question, "Could you please walk me through the process of how you came up with your opinions in this report?"

And I said, "Well, I - I suppose I have to start in 1994, when Blue Cross of California hired me to work with them in the controversy that they were having with the Department of Corporations and the legislature in California." And then on - it says, "and I was deeply involved in that process for the next two years."

Q So that controversy took several years to sort out?

A Well, the reference to the controversy is the controversy that existed in 1994. In 1993, Blue Cross of California took all of its non-Blue assets and dropped them, as I said earlier, into a wholly-owned subsidiary. And because it was not a conversion it did not require the dedication of assets

to a charitable purpose. Unlike there are two fundamental differences in the California and Alaska. The first is that Blue Cross of California was a public benefit corporation and every public benefit corporation of California is subject to a charitable trust. So there was never any doubt that if Blue Cross dissolved or converted, there was a charitable trust obligation on that corporation.

And the '93 transaction did not trigger that. It was approved by the Department of Corporations. The legislature became concerned that the transaction had been a de facto conversion but had been done in a way that did not invoke the charitable trust. So the legislature demanded a commitment of assets to charitable purposes. And there was an agreement set with the legislature to have Blue Cross of California create a charitable foundation and put 100 million dollars in the charitable foundation, and donate five million dollars a year over a course of 20 years to charity.

A new commissioner of corporations was appointed, and the new commissioner of corporations demanded greater commitment to charity and threatened an enforcement action. That's the controversy and the state of affairs when I was asked to be involved.

The commissioner of corporations then requested, and I think the letter is in the file in someone's testimony, there's a May 6th, 1994 letter, the commissioner of

corporations wrote to Blue Cross and delivered to the Wall Street Journal simultaneously demanding a - I think it was 40 percent of the stock of WellPoint for a charity. That's May of '94. And in June of '94, the Blue Cross/Blue Shield Association changed its rules to say that you could have a for-profit licensee.

So we went from 100 million to a demand of stock that would be worth about a billion. And then in June, when BCBSA changed its rules, I was told we're going to convert and we're going to give all the stock to charity. So, that's the nature of the controversy that we were in at the time. And the interesting thing to me is that not only - and it's true that the commissioner of corporations was being aggressive, and really appropriately aggressive, I think he did a good job over those years. But as soon as BCBSA changed its rules, the Blue Cross position trumped the commissioner and offered basically three billion dollars instead of one billion. So when we talk about unlocking the assets, that's really what it's all about. The mechanism of the conversion takes those assets that are tied up in the business and permits them to be put over here in the charitable foundation that can function while the business meets its capital needs through a new market mechanism.

I'm sorry, I realize you're on a time frame, but I'm - I'm passionate about the subject.

MS. HAMBURGER: That exhibit is Exhibit I-64, and I'd like to move to admit it at this time.

MR. MITCHELL: I'm sorry, which exhibit?

MS. HAMBURGER: I-64.

MR. MITCHELL: No objection.

MS. deLEON: (Shakes head.)

JUDGE FINKLE: Admitted.

(Exhibit No. I-64 admitted.)

MS. HAMBURGER: I have no further questions.

MS. McCULLOUGH: Judge Finkle, I have a couple questions, if that's okay.

CROSS-EXAMINATION

BY MS. McCULLOUGH:

Q Mr. Reid, I'm Amy McCullough and I'm here on behalf of the Alaska Intervenors.

On page eight of your pre-filed testimony, would you turn to that. Direct, I'm sorry. Your direct?

A I see it.

Q Here you give some examples of the work that the California Endowment has done with their money it received from other California conversions; is that right?

A That's correct.

Q In the second full paragraph, beginning on line 18, you state in there - I'm sorry, on line 21, "In each community in which housing was constructed there were health facilities and programs funded," et cetera. I'm wondering how many communities are you talking about?

A My recollection is that as of September 2003, there were 23 communities funded, and in the aggregate, 13 million dollars in loan funds went into those. And forgive me if I can't tell you how much of the 11 million dollars in grant funds went into those communities.

Q Okay. And in each of those 23 communities, housing projects were established; is that right?

A Yes.

Q And you list here a number of results from the funding, such as there was a decrease in concerns about dirt and garbage in the streets, concerns about drug use decreased, and a decrease in the noise or trouble from drunks; is that correct?

A That's correct.

Q And were these improved conditions due to an increase in access to healthcare or were they due - were they due to the development of adequate housing?

A You used that - you tacked that word care onto health again, and you - there's not a right or wrong. And it could be that one would decide to have a foundation that dealt only with

healthcare. If you did, from what I know about the social determinants of health, you would leave out the major factors that influence the health of our communities. Probably 50 percent of our health is related to behavior, another 20 percent more or less to environment, and only maybe 10 percent to the healthcare delivery system itself. So, some of what happened in those communities related to healthcare, other things related to health.

In the California Endowment, we take quite a broad view of what is involved in health in order to attack all of the social determinants of health. And as I heard the testimony and looked at the four bullet points of the major healthcare needs in Washington, the needs identified and the purposes in the Articles of Incorporation right here in Washington seem quite consistent with the view that we take in the California - California Endowment.

Q Okay. So, then, how much of these results could be attributed to the development of adequate housing?

A I can't tell you that.

Q Okay.

A I'd be happy to provide you with the evaluation of the project, but I can't assign a percentage.

Q Okay. And the health facilities that were constructed in these communities, what services did they provide, do you know?

A Well, some were clinics. Some took over buildings like community centers and organized providers to come in and provide the healthcare services in there. If you're familiar with the prometores (phonetic) programs in Latino communities in which lay healthcare workers are trained to become advocates and intervenors, if you will, on behalf of the health of the community, in some of the communities prometores programs were provided. I gave the example earlier this morning of an example where a rural hospital that had been closed had been turned into a community health center.

Q Okay. And you said that some of these clinics provided health care services; right?

A Yes.

Q And by that do you mean they provided direct care to patients?

A Yes.

Q Okay. So, is it fair to say then the quality of life in these communities improved due to increase in their access to healthcare?

A If you were able to go with me to Cutler, California, you would be astounded in the difference in the living conditions of before, seeing the trailer park that the workers lived in before, and the housing and the community enthusiasm built around the housing, and the health facilities and the health

education. Yes. Yes, the answer to the question is yes.

Q And I think earlier you testified that you didn't know anything about the insurance market in Washington; is that correct?

A That's correct.

Q And do you know anything about the insurance market in Alaska?

A No.

Q Okay. And if you'll hold on just one moment, I need to confer with counsel and see if I have any further questions.

A Sure.

Q No further questions. Thank you.

REDIRECT EXAMINATION

BY MR. MITCHELL:

Q Mr. Reid, let me see if I can go back in somewhat reverse chronological order. The first thing I want to ask you about is the selection process for the Washington Foundation. And the suggestion, I think, was made that the process that has been gone through thus far to define the purposes of the Washington Foundation and to consult with various people about that may have been insufficiently broad. My question to you is, does it make sense to you at this stage to start

over that process?

A Absolutely not. If I said that, that's not what I meant. I think the meetings that have been held thus far have been very useful, but I do believe that either the - before money starts to go out the door, either the attorney general, under the attorney general's auspices or the auspices of the board of directors of the foundations, there should be a broad outreach to the community, and that broad outreach should engage community groups around the state and should permit them to have an input into what the needs are.

I'm confident, since seeing this again and again, that even though I've never lived in Washington and never bought insurance in Washington or been treated by a doctor in Washington, I'm confident that our problems in different parts of the West Coast are very similar. So...

Q Let me ask a follow-up question, if I might. The question is, sir, whether the purposes of the foundation as they are spelled out in the Articles of Incorporation, speaking now of the Washington Foundation, are sufficiently broad in your mind to have the foundation later target appropriate uses of funds based upon input from broader constituencies.

A Were you going to put those on the screen?

Q I was endeavoring to do so but not succeeded. There we are.

A I think they are first, if you look at the underlying language at the top, it says "Promote the health of the

residents of the state of Washington." This is the point at which I'm quite sensitive about the use of the word care. I'd be concerned if the word care were in there because I think that would significantly constrain the potential for the foundation. If you come down to the second bullet point, again, we're talking here about access to healthcare, but it also says access to healthcare-related services. So, there are a broad range of social services which aren't really part of the medical delivery system but which have an important impact on the health of the community. So that's an important one.

Improving health education and awareness is really an important part of what, in our mission in California, we call improving the health status of Californians. And in the other slide that was used this morning just before this, it talked about wellness, which is wellness in prevention, the third slide. This is - that really is addressing the issue that I mentioned of behavior because our behavior, whether it's alcohol or drug use or tobacco or sexual conduct, our diet, our lack of exercise, these are the things that really determine 50 percent of our health. And to the extent that we don't deal with those issues, we're just creating problems that then come into the system and help to contribute to the health crisis that we have in the system today. So, and it's - I know insurance companies are trying to deal with those

problems, I know governments are trying to deal with those problems, but they're really not ideally suited to do that. And so foundations are in a unique position to be able to deal with those problems.

Q Mr. Reid, in response to questions from Ms. Hamburger about the circumstances in which the Blue Cross of California conversion occurred, you observed that California law is different than Alaska law. Did you mean to say Washington law?

A I did. I have not looked at - yeah, I have not looked at the Alaska corporate law.

Q You said, I believe, that in California the Blue Cross entity was, by statute, a public benefit corporation, and that certain consequences followed from that; is that right?

A That's correct.

Q Is it your understanding that Washington law defines public benefit corporations the same way or if Premera is a public benefit corporation?

A Well, it's my understanding from looking at the articles and looking at the Washington code that in Washington a nonprofit corporation can be organized for either a charitable or a number of other purposes, including commercial purposes. And that there is a separate section that says that you only become a public benefit corporation if you're recognized by the IRS as a 501(c) corporation.

So what I did was looked at the articles of the two corporations, saw what sections they were organized under, and confirmed that they were not nor had they ever been recognized as 501(c)(3) organizations. And I concluded from that that they were not charitable, that their assets were not charitable assets. Beyond that, I think it's really more appropriate to look to a Washington corporate law expert. I was just trying to understand the possible differences in the California model and the Washington model. And even in California, Blue Shield of California is not a public benefit corporation, it's a mutual benefit company, and I have seen opinion letters from their counsel that say that it's their subscribers who have, if there is a residual equity in a mutual benefit company, have the right to that, not the public.

Q Mr. Reid, there was some discussion early in the cross-examination about two boards, one being the new - the board for the new Washington Foundation, the other being the board of directors for New Premera. And I believe you testified that you saw those boards serving somewhat different purposes.

A That's correct.

Q Can you tell me which of those two boards you believe is appropriately focused on the benefits on running the business and on the benefits to the subscribers of the business?

A The New Premera board.
Q And do the two boards, as you see it, have different responsibilities that bear upon whether they should have the same - one should have control over the other?
A Well, the board of the foundation has a primary responsibility of meeting unmet health needs of the residents of Washington.
Q I want to ask you a little bit about the structure of two foundations versus one. And is it your understanding that the additional complexity attendant to the one-tier structure, that is the twin foundation structure in amended Form A, flows from the request made by the State's consultants that there be two foundations rather than one?
A Well, I don't know where the request came from. All I know is that the original Form A had a two-tier system and when I read the amended Form A it had a one-tier system. And the one-tier system resulted in the request for separate divestiture schedules, separate designated members on the board, and separate five-percent free voting of shares, and created complexity that will only be resolved if the two states agree on the allocation of shares between the states.
Q There's some discussion of a desegregated divestiture schedule, Mr. Reid. And I believe you observed in the context of that questioning that you disagreed with Premera. I would like you to perhaps explain the circumstances in

which your disagreement arose.

A Well, this was the one substantive change that Premera asked me to make in any of my reports, because I had written a rather critical treatment of the two - the two scheduled - two divestiture schedules, separate divestiture schedules for each entity, and it was something of an elaboration of what I said this morning. And Premera asked me to basically - basically to strike most of that or tone it down because they were at the time trying to persuade the BCBSA to go along with that and they were afraid that my analysis would somehow get in the way of their opportunity to get - to persuade the BCBSA to go along with it, to - to - the separate divestiture schedules.

Q Was it your understanding, Mr. Reid, that Premera was at that time attempting to advocate before the BCBSA on behalf of a position that had been requested by the OIC staff consultants?

A That's right. So I am still not fond of it, but I also believe, as the attorney general suggested this morning, that if the boards of directors of the two foundations conduct themselves appropriately, and recognize that it's necessary to diversify their investment portfolio, it's prudent to diversify their investment portfolio and they're going to have to raise cash in order to begin their charitable programs, that it's quite likely that they will be motivated

to sell the stock in a time that makes the combined divestiture schedule that's in the current documents not a problem for them. It's my belief that the most likely result is that this will be one of those things that five years from now everybody here will say, why did we really worry about that.

Q Toward the beginning of cross-examination, Ms. deLeon suggested that there are a large number of unmet health needs in our society, and that's true notwithstanding the first of health philanthropy discussed in your reports. My question to you, Mr. Reid, is whether you have reason to believe that the problems that exist today would be worse but for the efforts of foundations such as the California Endowment?

A Oh, I have no doubt about that. I'm comfortable with that. I think the report that Premera Watch counsel referred to a little earlier says, among other things, that as of the date of that report there have been something like 15 billion dollars in health conversion philanthropy created in the country. And you don't have to see very many models to understand the impact it's having.

I did say, with using the example of pouring water in the sand that if you spend all of your money on direct care, in response to the concern raised properly by Ms. deLeon, that this wouldn't seem like very much money, but there are times when spending money on direct care, if it can be - it

can be combined with the policy initiatives, can be very important. Do I have time to give an example?

Q Probably not. I think the stomachs are growling, Mr. Reid. The last question to you, sir, is this: Is there a potential rising from this proposal for a legacy for the residents of this state?

A Oh, I think it's a tremendous potential, because this is - this is an organization, the foundations, if they are created, it will be an organization that has the capability to last in perpetuity, to grow in influence, to profoundly affect health policy in the state of Washington, to energize hundreds of community-based organizations around the state, and I think leave a lasting legacy of improvement in the health of the communities.

Q Thank you. Nothing further.

MS. deLEON: No questions.

JUDGE FINKLE: Anything further from the intervenors?

MS. HAMBURGER: I just have two quick questions.

RECROSS-EXAMINATION

BY MS. HAMBURGER:

Q You testified before that Blue Shield of California says that they convert - they have an opinion letter that if they

convert, because they're a mutual benefit, they don't have to give any money over to a charitable foundation; is that right?

A Many years ago I saw such a letter.

Q Having that kind of an opinion doesn't mean that no regulator is going to hold them to transferring the full value of their assets upon conversion?

A Perhaps not, but there is a big distinction between a mutual benefit corporation and a public benefit corporation, and one of the experts for the OIC, I think it was Mr. Cantilo, referred to the life insurance conversions, which all resulted in the residual equity of going to the policyholders.

Q Entities could have - in a conversion, there could be different perspectives and different opinions about the legal requirements as a result of the conversion; is that right?

A Well, as you and I know, state by state around the United States in the Blue conversions alone, there have been different state statutory patterns and different decisions about whether there is a charitable trust imposed upon the assets, depending upon the nature of the corporations and the nature of the statute in case law in the state.

Q And that this - you testified before, you don't know whether any predecessor to Premera Blue Cross is a charitable organization?

A I do not.
Q Thank you.
COMMISSIONER KREIDLER: Mr. Reid, I had a couple of questions that I wanted to ask.

CROSS-EXAMINATION

BY COMMISSIONER KREIDLER:
Q One of them was that, as we heard yesterday in testimony that institutional investors could control 10 percent of the shares, but that was not true for the foundations together. Do you think that that is - that the same status should be - should exist for the foundations as does apply to the institutional investors?
A Well, by institutional investors, what they're talking about is mutual funds, so that the equity ownership is really spread widely, and I - I don't think I really have an opinion on that. I don't believe that the BCBSA has changed that particular aspect of the transaction from the time they imposed that on us in 1996 in California to the current date.
Q One of the issues that's been discussed this morning has been the issues relative to a divestiture schedule, which you point out in your opinion should exist. If that's so, then is the one that's specified right now in the Form A filing

the divestiture schedule that you'd necessarily recommend, should it be longer, more flexible, are there any differences that you would suggest as a part of the divestiture schedule?

A Well, let me contrast it with what we dealt with in California. First, in California we didn't have the one-year 80-percent deadline because the public already owned 80 percent of the WellPoint, after all the smoke cleared in the conversion. Beyond that, the schedule in California was much more severe than here, because there was a 20-percent deadline at three years, I believe, and a five-percent deadline at five years. So here, after three years, you have a 50-percent deadline or a 50-percent point, after five years a 20-percent point, and they've gone way out to 10 years for the five-percent point. And this also tracks with the IRS schedule, if this were a private foundation, because there the five-year deadline would be 20 percent. So, I really - my own belief is that the foundations will be anxious to diversify their portfolio, they'll be anxious to get money to do their charitable activities. We've just been through the bear market and my anticipation is that they'll be out of the stock faster than this divestiture schedule.

Q So you wouldn't propose necessarily any changes in the schedule as it's been proposed in the Form A?

A No.

Q I'm curious, what would be the impact on the value of the

stock held by the foundation if New Premera were to issue more stock, would that have a negative impact on the value of the stock held by the foundation?

A I would think not. But you have to understand, sir, that I'm not an investment banker. So take that as a footnote to what I say. The issuance of additional stock has two effects, one is that it helps in the divestiture schedule because the divestiture schedule isn't tied to the amount of stock that's issued to the foundations at the outset, and to the extent that there's additional stock issued in the IPO, for example, it will in itself reduce the shareholdings of the foundations even if they don't sell any stock. So, part of meeting the divestiture schedule, and it's probably not right to call it a divestiture schedule, it's a stockholding schedule, part if it's met by the additional stock that's sold by the company.

The other is that in our experience with WellPoint, the investment bankers told us, and it turned out to be true, that creating a market and increasing the size of the float in the market would enhance the value of the stock, so that the more stock we got into the market, the more liquid the market was, the more investors were willing to come into it, and the value of the stock rose accordingly. So, I think if our experience is any guide what will happen is that quite apart from general market conditions, the creation of a healthy float in the stock will enhance the value of the

stock and accordingly the value of the charitable endowment.
Q So issuing more stock after 100 percent of the initial stock offering was placed in the foundation would not reduce the value of the stock held by the foundation?
A I don't believe so. I think what will happen is it will contribute to a healthy public market and encourage investors and raise the value of the enterprise.
Q In California obviously there was no debate that took place or discussion or hearings on conversion because of, as you've described, the process that was followed in California. So there really wasn't a public process followed at that time for the conversion; is that correct?
A Well, that's right. I think all the same parties were at the table and the views expressed were very similar to the views that I've heard here and read in all the submissions. The process was very different. There was not an adjudicatory hearing. And if anything, Gary Mendoza (phonetic), who was then the Commissioner of Corporations, sat in the seat that you're in now and the - he had consultants much the same as the consultants that the OIC has here, all of the same kinds of topics were the subject of consultant reports. And then the parties that are Intervenors here were really people who had direct communication with the Department of Corporations. So, the DOC was getting the same input, and the difference, if you will, is that the DOC was receiving, filtering and

mediating that input, and then, in what I thought was kind of an extraordinary effort by a public official, was actually one-on-one negotiating the terms of the documents with Blue Cross.

Q So in effect the Department of Corporations then heads the debate on whether they could convert or not, or was it more of a debate on the question of how much money would be essentially set aside for a foundation for public purposes?

A Let me think back. I think the discussion by the time I got into it and by the time the BCBSA changed its rules shortly thereafter was not focused on whether there would be a conversion. I think - I think for the most part it was believed that the conversion would be a step forward both from WellPoint's standpoint, because they were in an awkward structure of having a New York Stock Exchange company with a nonprofit parent and a taxable nonprofit, and from the commissioner's standpoint, because he wanted a commitment of a much larger amount for charity. So, I think it's fair to say that, although some of - some of the parties which would be Intervenors in an adjudicatory process here, might have expressed to the Department of Corporations the view that there should not be a conversion permitted, I think for the most part the assumption was that there would be and it was the terms on which it would occur.

Q That's consistent with what I understood too. And I think

it's - that there was really no debate then on conversion, it was really much more of a debate then trying to - how do you salvage a situation that's gotten incredibly complex because of the effort that was made initially by WellPoint in transferring its assets to a for-profit entity; is that correct?

A Yes.

Q You raised the issues on tax considerations here for - would it be important to make sure that whatever foundation was created was considered as a 501(c)(4) so that there were no complications then for the tax considerations that you raised?

A Yes.

Q Is it correct that WellPoint, or I should say the California Blue's competition, before their conversion, was - their competitors were largely for-profit in California?

A I don't really know.

Q I think that was one of the points that Washington - Washington State is a very different environment, if in fact that was true in California. It isn't true here in the state of Washington where we've had such strong dominance by non-profits as - and I don't know what the conditions were in California.

A Well, certainly Health Net had already converted and created the Wellness Foundation. And you're well familiar with the

Kaiser, which is really a dominant player in California. But beyond that, I can't speak. I think UniHealth was still nonprofit at the time. But - so, there were at least big nonprofit players, but I don't have knowledge of what the market shares were.

Q Thank you very much.

JUDGE FINKLE: Follow-up?

MS. deLEON: (Shakes head.)

JUDGE FINKLE: Any follow-up?

MS. HAMBURGER: No, Your Honor.

JUDGE FINKLE: Okay. Shall we say two o'clock?

(Lunch recess.)

MS. EMERSON: At this time we call Dr. John Gollhofer

JOHN GOLLHOFER, M.D., having been first duly sworn by the Judge, testified as follows:

JUDGE FINKLE: Please sit down.

DIRECT EXAMINATION

BY MS. EMERSON:

Q Good afternoon, Dr. Gollhofer.

A Good afternoon.

Q Could you please state your full name for the record.
A John Gollhofer, G-O-L-L-H-O-F-E-R.
Q What is your occupation?
A I'm an obstetrician/gynecologist.
Q And how long have you been practicing medicine?
A Twenty-six years.
Q Who is your employer?
A I'm currently at the Rockwood Clinic in Spokane.
Q What is your relationship to Premera Blue Cross?
A I am an independent director of Premera Blue Cross.
Q And as a director, do you serve on any board committees?
A I'm the chair of the quality committee.
Q Can you please summarize for the commissioner your educational background.
A I graduated from Yale University in 1968, and I graduated from Washington University School of Medicine in 1972. I did a year of internship in St. Louis, Barnes Hospital. I then was two years in the National Health Service Corps, which is part of the Public Health Service. I was in a doctor-poor area, south coastal Oregon. I then finished my OB/GYN residency in Phoenix. And after that went to practice in Illinois.
Q Can you summarize for us, please, your professional career.
A I practiced, as I say, two years of family medicine with the Public Health Service in south coastal Oregon. I was then in

a large multi-specialty group practice in Quincy, Illinois, west central Illinois. I was there from '78 until '90. And from '90 until now I'm at the Rockwood Clinic.

Q And where is the Rockwood Clinic located?

A Rockwood Clinic is in Spokane, Washington.

Q Besides your board work for Premera, what other organizations have you done work for, been affiliated with?

A As you know, my day job is - and night job too, I guess, is delivering babies. But I realized early on there are things that we can do to help the healthcare delivery system and the health status of our population in terms of systems activities. For that reason I got involved in organized medicine early and have been a member of the state and county societies from starting practice. I served as president of the county society in Illinois, and then I served as president of the county society in Spokane, and also was president of the Washington State Medical Association in the year 2000.

Q And are you affiliated with any other organizations? Do you serve on any other boards?

A No, I do not.

Q Now, your pre-filed direct and your pre-filed responsive testimony have been filed and served in this proceeding. Do you adopt that testimony?

A Yes, I do.

MS. EMERSON: Dr. Gollhofer's pre-filed direct and responsive testimonies have been pre-marked as Exhibits P-18 and P-19 respectively. With the adoption of his testimony, Premera now moves to admit these exhibits into the record.

MR. HAMJE: No objection.

MR. COOPERSMITH: The Intervenors have no objection.

JUDGE FINKLE: Admitted.

Q (By Ms. Emerson) Other than as a subscriber, how did you come to be acquainted with Premera?

A I came to be acquainted with Premera and the other health plans in my service with the Washington State Medical Association. As president of WSMA, we were quite critical of a number of the health plans, and one day I got a call from John Castiglia, who is still the medical director of Premera, and they said he'd like to meet with me. And there was a little trepidation, I'll say. And Jeff Collins and I were actually traveling from Olympia, and we met John at the airport, and we all - Jeff and I were there before John got there. John came in, he sat down, he opened up a notebook and said, Now, what can we do for you to help make this right? And then Jeff and I proceeded to tell him for about an hour what we thought he could do to help make it right. And I think Premera's been working hard at that ever since.

About a year after that, Premera asked me to come and

speak to one of their managers' meetings, which I did, giving I guess you'd say the physician's perspective on the situation in healthcare.

Sometime after that, then I received a call from Gubby Barlow asking if I'd be interested in being on the board of Premera. I was a little surprised at first but then realized that it really was an opportunity to maybe make an impact in terms of the healthcare delivery system in a way that I hadn't really considered doing before. And I was very pleased to join the board and I've enjoyed serving on the board.

Q Now, you mentioned that on the board you chair the quality committee. I'd like to ask you some questions now about some of Premera's quality initiatives. First of all, what is the purpose of the board quality committee?

A The board quality committee essentially functions as kind of the medical side of the board activities. As such, we have - there are four members on the board, three are physicians. I'm an obstetrician/gynecologist, we have an otolaryngologist, and neurosurgeon, as well as a labor leader. The quality committee is charged with ensuring that the health status of the members of Premera as well as the satisfaction improves over time. And our committee is charged with reviewing and setting policies and holding the Premera management accountable that those policies and

activities are instituted successfully.

Q I know your pre-filed testimony does discuss some of - a number of Premera's quality initiatives, and I know that we'll hear from Dr. Chauhan later on in this proceeding who will address those in some more detail. But at this point could you help the commissioner understand the nature of those quality - those programs, could you please give us a summary?

A As I say, the purpose is to improve health status and satisfaction of members. Of course going from that to implementation and policy is tricky. We have a number of programs that we are using and that we are very proud of. I'd say Dr. Chauhan will discuss those in detail. I'd just like to say that the thing we are most active in would be our disease management and our case management activities. In terms of disease management, we have a fantastic healthcare infrastructure, as you are aware of, but we are not always integrated, as I think you pointed out yesterday. And where Premera and the quality committee sees a major opportunity is helping to integrate those activities.

As an example, I recently had a patient, a very fine young woman who unfortunately was addicted to narcotics. We were taking care of her obstetrically. She had an outpatient addiction treatment that she was in. She came in and delivered her baby. Her baby had major issues and was in the

intensive care unit. We had the whole challenge of inpatient drug treatment because the outpatient treatment of course couldn't come into the inpatient setting. And then of course when she was ready for discharge we had all the issues of getting her back to the outpatient treatment center, giving her the infrastructure to help continue to come and see her baby in the nursery, who was undergoing withdrawal treatment.

A long way of saying that somebody has to coordinate all of this activity, and it really fell to me to do that. And in this case I really wasn't comfortable I was doing a great job, and had she been covered by Premera I would have simply called the case manager for Premera and said hey, take over here. And that person would have been responsible for coordinating all of those activities.

With proper case management you can facilitate admission, you can facilitate care in the hospital, and especially facilitate absence of re-admission.

We also have chronic disease management programs, which again as you are aware, the chronic diseases involve a lot of major health - it's sustaining issues with a lot of different specialists, a lot of coordination, whether it be diabetes, which requires ophthalmology and podiatry and all these other folks to be involved. In say adrenal disease, which has a lot of complicated management issues, and especially keeping track of, the grant needs to know when there's likely to be

progression. We are very proud of Premera's programs that deal with these chronic disease issues that help to optimize the management. So that we optimize the treatment, we tend to prevent progression and tend to prevent complications.

Q Can you describe for us how these quality initiatives can impact utilization issues?

A Well, as I was saying, I think that - you know, I guess the mantra of our programs is that the right care at the right time and the right setting. And of course if you do all of those things well, you are going to minimize the cost, as well as optimize the outcome.

Q Can you describe the company's commitment to the quality initiatives?

A Well, of course in the quality committee there are three physicians and one non-physician. We get to the board and it's a little bit of the opposite. And again, it's our - my job really is to present to the board the exciting aspects of what the quality committee is doing. And again, I think it's working. The board is always very responsive to the presentations. The board is clearly committed to implementing these programs and clearly is behind what we are doing philosophically and organizationally.

Q And from your view and your vantage point, what is the Premera management's level of commitment to these programs?

A It's extremely high.

Q Overall, can you describe for us from your view how the conversion will impact these patient quality programs?

A I think the conversion will have a very positive impact. Now we have - and I told you the programs we are so proud of, but of course that's maybe five diagnoses. And I think the ICD-9 book, help me if I'm wrong, Bob, has 700 diagnoses or something. And again, wouldn't it be nice if we could take that to the top 10 or the top 15 or the top 20, which is where we'd like to go, but of course that requires a lot of investment. That requires software, hardware and personnel to administer those programs.

Q Dr. Gollhofer, as you know, some of the Intervenor witnesses have commented negatively on Premera's relationship with providers. They've also expressed concerns about working with Premera after a conversion. How do you respond to those comments?

A My own experience with Premera as a provider has been very positive. And this long antedates my being on the board.

In the old days, MSC maybe 10 years ago or so, there were pre-authorizations and other sort of utilization - stringent utilization management programs. And I think I heard from Bill once regarding a proposed hysterectomy. I haven't heard from anybody from Premera since then. I have no issues with authorizations or restrictions. I don't get called asking me why I'm using this drug or that; I just

don't hear from them. So I guess I'd say I don't find any healthcare management hassles with Premera at all.

Q You mentioned someone named Bill contacting you. Can you tell us who he is and when he contacted you?

A I'm sorry, Bill Marino (phonetic). You remember Bill was the medical director there probably 12 years ago.

Q And for the - 12 years ago that you contacted him --

A Must have been, yeah. Sorry.

Q Some of the witnesses have commented that Premera is even among the most difficult to work with among all health plans. Can you comment on that, please?

A You know, again, I don't find them difficult to work with. I think the disease management programs probably help a lot of physicians and facilitate their care of patients. I don't have any patients who fall under those diagnostic categories. But again, I find Premera easy to work with. And again, I guess I'd say that's my individual experience. I think there may be others who have other individual experiences, but of course we have some data that would back up the fact that physicians in general are very satisfied with Premera's behaviors.

Q Can you please open your notebook and turn to Exhibit P-38, please.

A Yes.

Q Dr. Gollhofer, can you describe for us what Exhibit P-38 is,

please?

A P-38 is a high-level summary of a survey that was performed at the request of Premera by an independent research organization regarding physician satisfaction.

Q And when was that presentation done?

A I presented this - it was presented to the quality committee on February 10, and I presented it then to the board on February 11, '04.

MS. EMERSON: At this time we would move to admit Exhibit P-38 into the record.

MR. HAMJE: May I have a moment to take a look?

JUDGE FINKLE: Yes.

MR. HAMJE: The OIC staff would object; no foundation.

JUDGE FINKLE: Could you provide a bit more foundation, please?

Q (By Ms. Emerson) Dr. Gollhofer, as a member of the quality committee for the board at Premera, what kind of feedback would you receive about provider satisfaction with Premera?

A Part of it - an integral part of the quality committee activities would be to know the satisfaction of our customers, among them being the physician customers, and to get feedback from them as to how we could do better, in what ways we could do better. As a member of the WSMA leadership, one of our major issues was the hassle factor in transactions

with insurance companies. The hassle factor not only sort of zapping one's energy but also costing overhead.

And again, the health plans and organized medicine as well as the hospital association have been working together, oh, my, I think it's about six years now, originally group - an informal group called the Guaymas Island Group that ultimately then became the healthcare forum - blanking on the name, senior moment - the Washington Healthcare Forum. And now that's a formal organization that continues to work together to try to diminish the transactional hassles. But as part of Premera's quality committee activities we want to know what the physician perception is of our relationship with them. Because obviously if they are dissatisfied with us in some regard, we'd like to fix that, we'd like to make it right.

Q And is Exhibit 38 the kind of feedback that you rely on in the conduct of your affairs as a member of the - the chair of the quality committee?

A Absolutely. I mean what we are looking for is data; we are not looking for anecdote. We are physicians there, forgive us, we try to act as scientists, so we want to have some data.

Q And I'm sorry, was it your prior testimony that this is information that was presented to you by Premera after it conducted - or had an independent forum conduct a survey for

patient satisfaction?

A Yes.

Q I'm sorry, provider satisfaction?

A Yes, that's correct.

MS. EMERSON: At this time we would again move for the admission of this exhibit into the record.

MR. HAMJE: No objection.

MR. COOPERSMITH: And Intervenors do have a point of clarification. Does Exhibit 38 represent the entire item, the entire survey summary?

THE WITNESS: Yes, I think it does.

MS. EMERSON: It should be complete.

THE WITNESS: The summary. It's not the whole --

MR. COOPERSMITH: It represents the entire summary?

MS. EMERSON: It's the presentation, yes.

MR. COOPERSMITH: That's what the witness can confirm?

THE WITNESS: Yes, sir. This would be, if you will, the slides derived from the PowerPoint presentation that was presented. It's in its entirety because we always end with the questions slide. So yes, I'm sure it's all there.

MR. COOPERSMITH: Thank you. The Intervenors have no objection to the admission of Exhibit 38 at this time and would request the underlying - the supporting documentation

as well. Thank you.

JUDGE FINKLE: Thirty-eight is admitted.

Q (By Ms. Emerson) Dr. Gollhofer, could you please highlight for us the key findings from this survey?

A In terms of methodology, this was an on-line survey regarding physician satisfaction. The physicians did know that the survey was from Premera. It was a random sample. As you see, almost 5,000 physicians were sent this - were invited to participate. As you can see, there tends to require an honorarium to get participation. Ultimately, about a - a little over 11 percent of the contacted physicians did return - did respond and complete the survey tool, which is about what one would expect with a survey such as this.

You can see there was a relatively equal response from Washington - proportionately from Washington, Oregon and Alaska. And then the responses were weighted by the aggregate number of physician providers in the areas. Then on page - the next page, overall satisfaction among physicians increased significantly in '03 from '02. This is something done annually, I should have clarified that. So I'm on page three now of the...

The mean rating improved from seven point three to seven point seven on a 10-point scale. The real significant issue here though is that physicians rated Premera much better or better than other health plans they contract with, 75 percent

did in '03, and you can see 60 percent had in '02. So not only had there been significant improvement for that period of time, but three-quarters of physicians felt that Premera was better or much better. And in fact, if you add in the number that felt it was equal to, it comes to 96 percent. So really only four percent of responded physicians felt that Premera was less good than the other health plans that they contract with.

And of interest was, the highest impact on satisfaction was the ability to resolve questions regarding payments and the promptness of claims reimbursements, things that I guess we maybe have been criticized by in other individual cases.

Q I know you've heard it said in this proceeding that some providers feel that Premera's reimbursement rates are too low, and concern has been expressed about provider reimbursement rates decreasing if the conversion happens. What's your response?

A I guess physician providers have historically complained that reimbursements were too low, and I don't know that that's ever going to change. The complaints I think have gotten louder recently because overheads have climbed so steeply.

As far as I can tell, physician compensation is determined by market forces, it's not determined by any one individual insurance payer in the marketplace. Having said that, I would qualify by saying I suspect that payment really

is set by Medicare, by HSA, and everyone sort of devolves from there. For all intents and purposes, an individually contracting health plan is going to have to pay the market rate or they are not going to have providers.

Q How do you respond to those witnesses who claim that Premera is somehow expected to compensate providers for low government reimbursement rates for their Medicare and Medicaid patients?

A In the Intervenor pre-filed testimony was made reference to the fact that Medicaid pays us abysmally - sorry, I'm paraphrasing, that government programs don't pay as well as they should, and that we rely on the commercial programs to sort of make up the difference so that we can cost shift. And again, that's what we historically have done. That of course puts a terrific pressure on the premium. If the health plan has to collect enough money to not only pay for healthcare services to their members but also to pay for healthcare services to government-sponsored non-members - and of course as a Premera provider, I'd like to see them do more of that. As a Premera subscriber, on the other hand, I sure don't want to pay more premium to subsidize all those other patients. I think to expect commercial carriers to continue to subsidize the state- and federally-sponsored programs is just not realistic.

Q You stated in your pre-filed testimony that providers need a

strong insurance market as much as insurance - insurers need providers. Can you explain what you meant by that?

A Some of us remember the bad old days when the Unified Physicians of Washington came on with such promise and enthusiasm and so many of us invested a significant capital into that company. Evidently that wasn't enough capital and the company, as you are well aware, didn't do well. I think it was two years and it ended up in the commissioner's lap. That was formed by the physicians in an attempt to right the perceived wrongs of the health insurance industry, and I think we realized or many of us realized that, you know, you need an expert to run an insurance company and it can't be done by amateurs.

In Spokane, again as the commissioner is aware, we had the very unfortunate issue of Spokane Health Link, which was an intermediary, collected monies and never - it was insolvent and was unable to pay those monies to the providers. And a lot of providers - and then went into bankruptcy, and the providers not only had to go without the cash flows, in some cases they even had to refund some of the monies they had been paid under the terms of the bankruptcy ruling and ultimately were left holding a lot of bad debt.

And then a major example of course was Kitsap Physicians. Again the commissioner is familiar with that situation. That company became under-capitalized, and in

order to, my understanding was, to rescue the company, physicians and other providers actually forewent receipt of monies I think for three months, wasn't it? Something like that. Anyway, there was a three-month hiatus in cash flows to providers while they recapitalized the company.

In other words, whether providers - whether we providers like it or not, we are dependent on strong, solid, effective, efficient third-party payers, insurance companies to keep this whole healthcare system going. And from that standpoint, I've said that the first time I testified at one of the committee hearings, and I've been saying it sense, I believe the conversion is important to help Premera stay strong. And I think a strong Premera is in the benefit of all of us: providers, subscribers, and those of us in public policy.

Q Dr. Gollhofer, how many health plans do you currently serve?

A The two big health plans in my practice of course are Medicare and Medicaid, and that's probably a little over 50 percent. The other 50 percent would be divided among the players in Eastern Washington. And I would guess that Premera's probably, of the 50 percent that's left - sorry, let me do the math. So of the 100-percent pie, Premera is maybe 15 percent, Group Health is maybe 14 percent, then of the remaining 20 percent that's a smattering of Regence Asuris, the TRICARE programs, PHCO, Aetna, the Carpenters

Union Trust is a big one. So there's a lot of different - different commercial payers that I deal with.

Q And have you seen the number of health plans that the Rockwood Clinic is serving increase in the last five to seven years?

A I think, you know, it's stayed about the same. You know, there have been some players pull out of the market. You know, QualMed is gone but Molina is there. The Regence wasn't there but then has come in pretty strong with their Asuris product. Sisters of Providence was there and they are not there. So I think there's an ebb and flow of insurers into the market.

Q Your pre-filed testimony addresses the potential impact of the conversion on Eastern Washington and rural communities in particular. What's the basis for your views?

A Living and working in Eastern Washington I have a lot of familiarity and a lot of vested interest. And I'll say that Premera has stuck with us through thick and thin, through the bad days of the late '90s and they are still here now. I know from my service on the board that Premera needs a statewide network, it needs a full network. That's really one of their major assets. And they are not going to do anything that's going to jeopardize that statewide network. I believe that Premera is there for the long run and has a commitment to Eastern Washington.

Q Do you think the conversion will lead to lower reimbursement rates for providers?

A No, I do not. As I stated, I believe that providers are paid on the basis of market forces. I don't think the conversion is going to have any affect on that at all. I think where this is coming from is the implication that for-profit health - implication of the statement that for-profit health plans are going to concentrate on profits and nonprofit health plans will concentrate on service, and there's just no factual basis to make that statement. But at this point I would like to refer to the article that was introduced in Sally Jewell's testimony yesterday, if I may, and I think that was P-3.

Q The New England Journal of Medicine Article?

A The New England Journal of Medicine Article.

Q I believe that was P-3.

A And again, I understand that, you know - I was a molecular biology major so forgive me with this, but this article I find very exciting reading and very fascinating reading. If you look at the authors, these are three - these authors work at Harvard. I mean these are top-quality guys. And up front they state their hypothesis, which is, "We tested the hypothesis that the rates of use of 12 common high-cost procedures would be lower in for-profit health plans than in not-for-profit health plans." So that's the same hypothesis,

if you will, that the Intervenors have been sort of bringing forth. But here they tested it scientifically. In fact, they looked at HEDIS data on three and a half million beneficiaries of 254 health plans. So that's a huge, huge base of data that they are working from. So what they - so their conclusions are going to be accurate from a statistical standpoint.

"Conclusions: Contrary to our expectations about the likely effects of financial incentives...." So again, they were up front about the prejudice that they brought to this study, not unlike the prejudice we see being brought to this argument right now.

"Contrary to our expectations about the likely effects of financial incentive, the rates of use of high-cost operative procedures were no lower among beneficiaries enrolled in for-profit health plans than among those enrolled in not-for-profit health plans." So in other words, there was no difference in provision of service or access to care whether the plan was profit or nonprofit, which is the point that I've been trying to make all along, that what determines behaviors has nothing to do with the profit or not-for-profit status.

And then, if I may, I'd like in that same article to turn to page - it would be listed as page 148, so before the end. I'm going to be reading under Discussion. "There is

widespread concern that the financial incentives of managed care will lead health plans, particularly for-profit health plans, to restrict Medicare beneficiaries' access to important healthcare services, such as high-cost operative procedures. Despite this concern, we found no evidence that enrollees in for-profit plans were less likely to receive such procedures. This was true for both 'low-discretion' procedures..." You could argue that if somebody has a hip fracture, you know, they are going to get that fixed. That's not a discretionary expenditure, if you will, by the health plan.

But also, reading now from the top of the next column, also, "and a 'high-discretion' procedure, such as hysterectomy (for which in many cases there is less consensus about the benefits and risks of the procedure)." In other words, if a health plan were trying to maximize its profits, it could conceivably make it pretty difficult to get a hysterectomy, because unless it's cancer, those patients are rarely critically in need of that healthcare intervention.

And then I just want to go to the last - start this next paragraph, and then I'll stop boring you with this article. But... "Our results are somewhat contraintuitive." Well, only if you prejudice in the first place that you figured the for-profit plans were going to be misbehaving.

"Health plans can select from a long list of strategies

to influence the use of clinical services." But they didn't. So I guess - I think this is high-quality research that proves the point that I think I've been trying to make for the last several months, which is that whether a plan is for-profit or nonprofit is irrelevant in terms of how it's going to behave in terms of healthcare beneficiaries.

Q Thank you, Dr. Gollhofer.

MS. EMERSON: No further questions at this time.

CROSS-EXAMINATION

BY MR. HAMJE:

Q Doctor, my name is John Hamje. I am a special assistant attorney general appearing on behalf of the staff today.

I would like you to please, if you have it in front of you, Exhibit P - let's see, P-18, please. If you would turn to page five of that exhibit, please.

A I will.

THE WITNESS: Can you still hear me okay?

COURT REPORTER: (Nods head.)

A Yes.

Q (By Mr. Hamje) The answer to the first question, the last sentence, you say "The proposed conversion will help provide the capital the company needs to make those investments."

And by "those investments" you are talking about the company's care facilitation, disease management, and other healthcare quality programs?

A Correct.

Q If Premera does not convert, will that affect Premera's investment in supporting and growing these programs?

A In supporting the programs, I would think not. In growing the programs, I would think possibly. In other words, you know, as a clinician I'd like to see us go from five or six to 25 or 26. And that's the pressure Premera gets from us. And of course the reality is that it takes money - it takes capital for the investment in the hardware, software and personnel to allow for that to happen. So I guess I'd say that if we had - again, help me, I'm not a Ph.D. in economics, but my sense is if we had access to capital, more ready access to capital, we could have more rapid starting up of these additional programs.

Q So you are suggesting that without the conversion, the programs, growing them - you wouldn't be able to grow them as quickly or have as many of them grow, is that --

A That would be my - yes.

MR. HAMJE: That's all we have of this witness.

(Continued on next page.)

CROSS-EXAMINATION

BY MR. COOPERSMITH:

Q Good afternoon, Dr. Gollhofer. Let me begin my expressing my personal regard to you and my personal gratitude for your participation in this conversation today. Let me also express on behalf of the WSMA the great regard the association has for the outstanding care you have provided to patients over the years and also for your distinguished service as WSMA president.

A Thanks.

Q Turning to the healthcare initiatives to which you just testified, you mentioned that Premera has a program on disease prevention, on chronic disease management, and health education, among others; is that correct?

A Yes.

Q And that all of these initiatives are under way now; is that correct?

A That's correct. But again, I just - those are - those are sort of general headings under which various initiatives are in process --

Q Correct, just using a description of those programs and they are all under way now; is that correct?

A Correct.

Q Thank you. And has the quality committee that you chair ever

designed a health initiative that Premera told you it couldn't do because it needed to convert first?

A No. Obviously the answer to that is no. But I would --

Q Thank you.

MS. EMERSON: If I could object, please. If the witness could be allowed to complete his answer.

JUDGE FINKLE: You can handle this on redirect. I think that was a yes-or-no question.

So go ahead, please.

MR. COOPERSMITH: Thank you, Your Honor.

Q (By Mr. Coopersmith) Can you tell us, Dr. Gollhofer, what was the net cost to Premera of their disease prevention initiatives?

A I don't know.

Q And can you tell us what the net cost to Premera was of any of the initiatives that you discussed today?

A I do not know.

Q You are aware that Premera said in its filings that it paid $125 million to develop and implement the dimensions program; is that correct?

A Correct.

Q And is it your belief that Premera has spent anything close to 125 million dollars for its healthcare initiatives?

A The activities under the quality committee are very dependent on that dimensions' operating platform in terms of

information management and acquisition of data. So I guess I can't really say that one is separate from another. And in terms of how much money, if you somehow did - if the accountants did break out that into various categories, how much money would be spent on the quality programs, as I said, I don't know.

Q And can you name for us three health initiatives that Premera could only do as a for-profit health insurance company?

A No, I couldn't.

Q Could you name two initiatives that Premera could only do as a for-profit healthcare insurance company?

A The initiatives we are trying to do all require capital investment.

Q I'm just asking a different question, Dr. Gollhofer. I understand your desire perhaps to answer a different question, but my question was very simple: Can you name two health initiatives that Premera can only do as a for-profit company?

A No.

Q Or even one?

A No.

Q Okay. Let's move on then. I gather from your testimony, Dr. Gollhofer, that you've never been a solo practitioner in this state, have you?

A Have not been.

Q And I gather from your testimony that you've never been in a small- or medium-size medical practice in this state either?
A No.
Q In fact, you've spent your entire career in Washington State at the Rockwood Clinic; correct?
A That's correct.
Q I think we can all agree that the Rockwood Clinic provides superb care to its patient; will you agree on that?
A We agree.
Q Excellent. And the Rockwood Clinic we understand serves about 120,000 patients a year; is that about right, does that sound right to you?
A I don't know.
Q Okay. Is it fair to say that the Rockwood Clinic serves, let me be precise here, a heck of a lot of people every year?
A We have a lot of patients. We have about 130 providers, and we are all working pretty darn hard, as is all the other providers in the state. So I'm not sure how you - you multiply that number, I don't know if it comes to 120 or...
Q You wouldn't be surprised if the web site for the Rockwood Clinic said that it served that many, 120,000 patients a year, would you?
A Wouldn't surprise me.
Q Would you be surprised if the web site for the Rockwood Clinic said it had 140 providers?

A You know, we just keep growing, don't we?
Q Apparently. And perhaps you will be surprised --
A But could you find us another obstetrician in that web site somewhere?
Q Never enough of them, I know.
Doctor, what about the number of staff at the Rockwood Clinic, the web site indicates that there's 600 staff. Would that surprise you?
A That sounds about right.
Q Okay. And do you happen to know how many satellite clinics the Rockwood Clinic has?
A I'm sure you got it from the web site. But let's see, there's Cheney and there's North and there's Valley and there's us, we are called South Satellite. There's Moran Prairie, there's Medical Lake, and there's The Heart Institute. So I guess that's seven satellites. And then the mother ship. I'm sorry, main building. Is that right?
Q Well, you only have about five more to go. But that's excellent. So 14 satellites --
A Oh, yes, physical therapy. Now, come on, don't do this --
Q No, it's not a test, Doctor. You are doing great. So, would you be surprised to know that there are 14 satellite clinics to the Rockwood Clinic?
A Fourteen? Yeah, I might be.
Q But a lot; right?

A Yes.
Q Somewhere between eight and 14 is what you would say? Okay. And that makes Rockwood Clinic the biggest clinic in Spokane, doesn't it?
A Yes, it does.
Q And it makes Rockwood Clinic the biggest clinic in the entire eastern part of the state, doesn't it?
A I believe it does.
Q And is it fair to say that you really can't have network adequacy in the Spokane area unless you have the Rockwood Clinic in your network?
A I would anticipate that is true, but I don't know, I've never tried to build a network.
Q Okay. So, Rockwood Clinic is really in the best possible position to negotiate a better deal with Premera then; correct?
A I would think if Premera wants Rockwood in the network, that puts us in a pretty good position to bargain, I would - yeah.
Q In fact, the Rockwood Clinic - thank you, Doctor. In fact, the Rockwood position does get a better deal; isn't that correct?
A I believe it's correct, but I don't know that for a fact.
Q You believe that Rockwood Clinic would possess better bargaining power with Premera than a solo practitioner; correct?

A Depends on the solo practitioner.
Q And can you elaborate on that answer? What type of solo practitioner would have more influence?
A If you are the sole subspecialty surgeon, you'd probably be in a better bargaining position. Let's say - and I'm trying to think of one and I'm not. But let's say for the gynecologic oncologist, there's two of them in Spokane, they both work at Cancer Care Northwest, I suspect they are probably in a better bargaining position, if you will, because you can't have a network without them.
Q And is that your understanding of a network with, I mean, subspecialists in it?
A Well, I'm not sure I know what you mean by network there. I thought I did, but maybe I don't understand your question. Could you define it for me?
Q No, that's fine. Well, I'll tell you what, Dr. Gollhofer, let's just focus in on the bargaining power of solo practitioners. Is it fair to say that the vast majority of solo practitioners, other than perhaps the two you just identified, would have less bargaining power than the Rockwood Clinic does with Premera?
A Again, I think it depends on the practitioner. For instance, there are two --
Q Doctor, I hate to interrupt, but I just asked whether it was your opinion whether the vast majority of solo practitioners

had less bargaining power with Premera than the Rockwood Clinic?

A And my answer to that question would be no, I don't think that's a fair assumption, and I was going to - in other words, the intuitive answer that you are looking for is yes; but what I'm trying to explain to you is that - I guess I shouldn't name names so I won't, but I can think of a two-person family-practice practice who is so respected in the community that it would be tough to have a network without having them in it. So they are not - they don't practice a unique specialty, but yet there are several thousand patients that I'm sure would scream bloody murder if they weren't in the network.

Q Do you believe that small practitioners - practitioners in small medical practices have the same amount of bargaining power as Rockwood Clinic does with Premera?

A That I don't know. As I say, they are - I suspect that the solo providers in GYN oncology have more bargaining power, as I said --

Q I actually asked about small practices, not solo practices.

A Sorry, I missed that. So help me --

Q Sure.

A I didn't understand the nuance. Give it to me again.

Q No problem. Here is the question. Whether it's your opinion that physicians who are in small practices have equal

bargaining power with Premera as the Rockwood Clinic possesses?

A I think that physicians in small practices can well have equal bargaining power depending on, A, the uniqueness of their specialty or subspecialty, or B, on the size of their practice and the desire for and the need for Premera to have those folks in the network, because all the subscribers identify those doctors as their doctor and they want them in the network.

Q So would you say, Doctor, that it is the general rule that a physician in a small practice or medium practice has the same power as - bargaining power as the Rockwood Clinic, is that the general rule or exception to the rule?

A I'd say that it's the - I would say it's a general rule for those established practices with patients in them, I guess you'd say. If you were just coming new to town - well, of course if you came new to Spokane your practice would be busy overnight anyway. So I guess I'd say that no, I don't think that's true. I think that Premera has a need for virtually all of the providers in Spokane to be part of their network because the subscribers expect them to be.

Q I just want to make sure we understand your testimony then, Dr. Gollhofer. You are saying that solo practitioners, small practitioners, practitioners in medium-size practices all have about roughly equal bargaining power with Premera as

Rockwood Clinic?

A I think they can have. But again, understand I'm not a labor lawyer, I don't do contracts. Have I been in these negotiations? I don't know. So --

Q Okay. Would you agree with Mr. Ancell's testimony that, quote, There are large - there are a large - or let me read my native language correctly. There are a number of large multi-specialty clinics throughout the state that are very important to try and include in the network. These clinics also have significant bargaining power with Premera, closed quote. Would you agree with that?

A I'm reluctant - I don't have that in front of me. I mean it sounds like a reasonable statement, but it may be taken out of context. And let me tell you what I mean by that. When you asked if you suspected Rockwood got paid at a higher rate than the two-person family-practice group, I'd say I suspect we do, but the reason isn't because we are such a bargaining behemoth, it's because we bring additional value to the transaction.

The two-person group has very little infrastructural overhead, doesn't have quality programs, doesn't have utilization review programs, doesn't have medical directors, doesn't have a pharmacy and therapeutics committees, doesn't have the reporting capabilities, quality score cards as it were, which of course Rockwood does have. So I think as we

come to - I would hope as we come to negotiation with Premera or Regence or anybody else, we get compensated something for all of the value that the organization is bringing to that interaction, to that relationship.

Q And Dr. Gollhofer, I'm assuming you are not implying that there may be inferior medical care delivered by a solo practitioner, a small practitioner or medium-size practitioner; is that correct?

A I would never imply that.

Q Okay. Good. Why don't we move on to your personal views of Premera then. You mentioned today and previously in your written testimony that, quote, The Premera board and management team is committed to working collaboratively with physicians, closed quote. Do you stand by that statement?

A I do.

Q And that, quote, Premera has been very proactive in seeking to address physician concerns, closed quote. Do you stand by that statement as well?

A I do.

Q Okay.

MR. COOPERSMITH: Allow me just a minute, Your Honor.

Your Honor, if I may, these are exhibits offered as impeachment. The parties do not... (Returning to microphone.) Your Honor, if I may, these are exhibits that

will be offered as impeachment evidence. The parties do not have copies of these yet. I would like permission to approach the witness, the bench and the other parties to distribute copies.

JUDGE FINKLE: Go ahead.

MR. COOPERSMITH: Thank you.

MS. EMERSON: I would offer that I don't think any basis for impeachment has been established here.

JUDGE FINKLE: Well, let's look at the document and then I may agree with you, we'll see.

MR. COOPERSMITH: I may approach?

JUDGE FINKLE: Yes, please.

MR. COOPERSMITH: Can we ask that that be marked as Intervenor's Exhibit 117, please.

JUDGE FINKLE: Is that the next in order?

MR. COOPERSMITH: Yes, for the WSMA exhibits. I believe that that's correct, but we can get confirmation.

MS. BEUSCH: Yes, that's the next one.

MR. COOPERSMITH: That is? Thank you.

JUDGE FINKLE: It will be so marked.

(Exhibit No. I-117 marked for identification.)

Q (By Mr. Coopersmith) Dr. Gollhofer, I'm showing you what's been marked as Intervenor's Exhibit 117, ask you to take a minute to review that exhibit and tell us if you recognize

what that is.

A This is a WSMA Reports dated January zero zero.

Q Well, it's actually January of 2000; correct?

A All right, 2-0-0-0.

Q There you go. The organization hasn't been around that long. And can you tell us what the picture of the handsome guy is on the first page of Exhibit 117?

A I don't recognize him: he's got a mustache. I don't know who that guy is. And all that gray hair? No, it couldn't be me.

Q Okay. But would you be convinced that that is what you looked like in the year of 2000?

A Yes, that is my picture.

Q Okay. And you've had an opportunity to review the exhibit; is that correct?

A No.

Q Can you just review it and see if you can tell us if that appears to you to be an accurate copy of the January 2000 WSMA Reports?

MS. EMERSON: We would ask that the witness be allowed sufficient time to familiarize himself with the document.

MR. COOPERSMITH: Sure.

JUDGE FINKLE: Yes, take all the time you need.

A And again, I assume you are talking about the lead article

here?

Q (By Mr. Coopersmith) Well, we are actually talking about the whole exhibit, we'll be asking you questions about your article of course, but take a look at what has been marked as Exhibit 117 and just tell us if you believe that to be an accurate copy of that publication.

A Again, I understand your time is of the essence, but again, this is a multi-page document, there's - I think I just saw an ad for a psychiatrist somewhere. So you don't want me to go through all of that stuff; right?

Q No.

A You are going to have to reference --

Q The article that you wrote in this exhibit, I just want to make sure that you believe - does that article appear to be an accurate copy of that - does the exhibit appear to be an accurate copy of that article?

MS. EMERSON: Again, I would respectfully make the request that the witness be allowed enough time to at least familiarize himself with the document.

MR. COOPERSMITH: No objection.

JUDGE FINKLE: Sure. Go ahead, please.

THE WITNESS: Thank you.

A So, the first question is, does this appear to be an accurate copy, is that --

Q (By Mr. Coopersmith) Correct.

A Yes, it does appear so. It does so appear.
Q All right. And can you tell us what WSMA Reports is?
A It's a newsletter that's published and disseminated to the members of the WSMA periodically.
Q And did this article appear during your tenure --
A Yes, it did.
Q -- as president of the organization?
A Yes, it did.
Q Did you review and approve this article before it appeared in print?
A No, I did not.
Q You did not?
A No.
Q Do you have - tell us what your understanding is of the review process before your name appears in the publication.
A I don't know what the review process is.
Q Is it your understanding that this article ran with your name and your picture, authored by you and you didn't see it ahead of time?
A Oh, it ran with my name and picture, but no, I didn't see it ahead of time. I think that was - yes, that was the substance of your question. And no, I did not.
Q And we are specifically referring to the article that is - that indicates is by you in that exhibit; correct? The one entitled - on page one --

A Where does it indicate it's by me?
Q It's an interview rather, excuse me. "In a recent interview with WSMA Reports." That's indicated on page one of the exhibit. Do you see that? It is the second paragraph.
A I see that statement, yes.
Q And do you recall giving that interview?
A No.

MR. COOPERSMITH: Your Honor, before we go into the particulars of the interview, we wish to move for admission into evidence Exhibit 117.

MS. EMERSON: At this time, Your Honor, we would object. There's no basis for the introduction of this document.

JUDGE FINKLE: Sustained at this time.

Q (By Mr. Coopersmith) All right. Dr. Gollhofer, did you ever give an interview with the WSMA Reports?
A No.
Q Do you then deny that the answers to the questions that are published here in Exhibit 117 are not your words?
A No, they wouldn't be my words.
Q If these were not your words, then what reaction did you have when this article appeared on the front page of the WSMA Reports publication in January of 2000? You must have been shocked and amazed; correct?
A No, I wasn't shocked and amazed. When I was president of the

Spokane County Medical Society, I wrote all of my own articles, as it were, and that was kind of a burden, you know. Once a month I had something to say --

Q Doctor, please, if I could direct you to answer --

A I am. That's where I'm going. When I was president - I'm answering your question. When I was president of Spokane County Medical Society, I wrote all of my own columns. When I became president of the Washington State Medical Association, I never wrote a word. Those were all produced at the WSMA's office. I was a little surprised when the first volume came out with an article supposedly authored by me that I hadn't written, but I was I guess you'd say gratified that I hadn't had to spend the time producing it. I don't know whether current presidents are writing their own columns or not, but in those days it was produced for us by the staff of the WSMA.

Q Dr. Gollhofer, I'm afraid you did not answer my question. The question was this: When this publication came out in January of 2000 and it attributed answers to you that you apparently never provided, what was your reaction? You must have been pretty angry; right?

A I was not angry, no.

Q What was your reaction then?

A I did not have a reaction to this article at all. As I was trying to tell you, the first time one of my columns came

out, I think I became president in September, and I suppose the first article was probably in October, and the first time I saw it I was a little bit surprised because nobody called me to ask me to write it. After that I just assumed the staff would be writing those. So, when there would be a president's column, as it were, on a monthly basis, I was no longer surprised. Does that answer your question?

Q Well, so then you never voiced any objection to what was put out under your name in January of 2000 WSMA Reports; is that your testimony?

A I did not - ask me the question again.

Q Sure. You never made any objection to the WSMA issuing this interview in your name; is that correct?

A That's correct.

Q All right. And turning to page four of that interview, could you please read the - that first paragraph that begins "In Spokane"? Do you see that, Dr. Gollhofer? It's the first paragraph. It says "Economic jeopardy," that's the --

A Okay.

Q Now start with the first full sentence of that page, please.

A The words read, "In Spokane, for example, we have essentially one commercial insurer, Premera, besides Group Health. Premera has over 70 percent of the local private market and is dictating terms to physicians; it's unwilling to negotiate. The problem isn't confined to Spokane, but the

physicians there are particularly threatened. Increasingly, we're seeing physicians dropping their contracts with insurers as the terms are just too one-sided."

Q Okay. Closed quote; correct? Well, that's quoting that passage; correct?

A I'm reading what's written. If you are saying are those my words, the answer is no.

Q If you didn't disavow those words then, do you disavow the words now?

A Yes. And of course it's four years from now, as I say. So I guess I would say that my experience with Premera, as I said in my testimony, it's been very positive.

Q Does that express - does the passage you just read, did that express your view of Premera at the time?

A No.

Q Let's move on to your characterization of Dr. Collins's testimony. You stated, quote, Dr. Collins's criticisms are the same criticisms that some physicians have directed toward all health plans, closed quote. Is that correct?

A That's correct.

Q And you say that Dr. Collins's clinical experience is the opposite of my experience at the Rockwood Clinic, closed quote, with Premera; is that correct?

A I'll verify this. Tell me where you are reading.

Q Sure. If you look at your responsive testimony on page two,

line --

A P-19?

Q I'm sorry?

A P-19, is that responsive?

MS. EMERSON: It is P-19.

MR. COOPERSMITH: Thank you, counsel.

A What page?

Q (By Mr. Coopersmith) Page two, I believe lines 11 through 12.

A Yes, I'm there.

Q Okay. Is that a - is that what you said, that, quote, Dr. Collins's statement about his clinic's experience is the opposite of my experience at the Rockwood Clinic, closed quote; is that what you said?

A Yes, that's what I said.

Q Okay. And you expressed the belief that Dr. Collins may be right in his criticism of the practices of other insurers, but that his criticisms aren't valid as to Premera; is that correct?

A Where do I say that?

Q If you look at the same exhibit, same page, line three. Lines two and three. Is that a correct characterization of your testimony?

A That's out of context, but --

Q The question is whether it's a correct characterization of

your testimony?

A How did you characterize it?

Q Sure. The question again --

MS. EMERSON: For the record, could we get some clarification as to what specifically counsel is referring to on page two?

MR. COOPERSMITH: Sure. Lines two and three.

MS. EMERSON: So, I'm sorry, the line two, the sentence begins on line one.

JUDGE FINKLE: Could you just be specific, please?

MR. COOPERSMITH: Sure. Lines one to three.

A And what was the question regarding lines one to three?

Q (By Mr. Coopersmith) Sure. The question is, is it fair to characterize your assessment of Dr. Collins's criticisms that some of those criticisms are true of the practices of some insurers, but that they are not valid as to Premera; is that correct?

A No, it's not --

MS. EMERSON: I'll object. Mischaracterizes the testimony.

JUDGE FINKLE: Could you read it directly and then ask the question?

MR. COOPERSMITH: Sure.

Q (By Mr. Coopersmith) Can you read into the record lines one through three of that page and then lines 13 through 17. One

through three and 13 through 17.

MS. EMERSON: If I could just make a request, please. Line one, it begins - it would not be a complete sentence. If the witness could --

JUDGE FINKLE: I'm assuming we are starting with the word "I" on page one?

MR. COOPERSMITH: Correct.

JUDGE FINKLE: Go ahead.

A "I do not believe these complaints are valid as to every health plan, and more specifically I do not believe they are valid as to Premera."

Q (By Mr. Coopersmith) And then lines 11 through - pardon me, lines 13 through 17, please.

A "For example, the billing process with other insurance companies can be onerous. We have to resubmit and haggle over an unduly large portion of our claims, many of which are ultimately denied. Premera, on the other hand, works hard to meet its commitments and solve problems to the mutual benefits of both parties."

Q Okay.

MR. COOPERSMITH: Now I'd like to approach the witness with what would be marked as Intervenor's Exhibit 118.

JUDGE FINKLE: Yes.

Q (By Mr. Coopersmith) Dr. Gollhofer, I've shown you what's

been marked as Intervenor's Exhibit 118 and ask you to take the opportunity to review it and tell us if you recognize it.

MS. EMERSON: Your Honor, at this point I would like to object to the introduction and the reference to this document. First of all, there's been no basis for any impeachment that's been established. And second, even if there is something in particular that Mr. Coopersmith is seeking to impeach with respect to pre-filed direct testimony or the scope of pre-filed direct testimony, the Intervenors clearly were on notice as to what the scope of this witness's testimony would be, and therefore pursuant to the pre-hearing scheduling order that you set forth, all such materials that were - could reasonably be anticipated were to be disclosed as exhibits at that time, and this submission does not meet the requirements of that order.

MR. COOPERSMITH: Your Honor, it was the Intervenor's understanding that the pre-filing of exhibits apply to all but exhibits offered for impeachment purposes.

JUDGE FINKLE: Exhibits related strictly to impeachment will be allowed for all parties. Go ahead, please.

MR. COOPERSMITH: Thank you, Your Honor.

Q (By Mr. Coopersmith) Dr. Gollhofer, have you now had an opportunity to review what's been marked as Intervenor's Exhibit 118?

A Yes, I have.
Q And do you recognize that?
A Yes.
Q And can you tell us what that is?
A WSMA Reports dated February 2000.
Q Well done. And on the first page of that exhibit, do you see an article where you are quoted?
A Yes, I do.
Q And have you reviewed the excerpts that you are quoted on?
A On the first page, yes.
Q On the first page, yes. Thank you. And do you recall giving those statements?
A No, I don't.
Q And did you in fact... Do you deny giving those statements?
A The job of being president of WSMA involves expressing certain policies and statements. As I referred to in my testimonies, organized medicine has been criticizing insurance companies for quite some time and I assume will probably continue to do so. WSMA policy and position is - was to be critical then and I guess is still to be critical. As a leader of the WSMA's executive committee, would I have participated in discussions regarding these issues and strategized regarding how to pursue them potentially, were those my words? I'm confident they weren't. And if I've ever used Rube Goldbergian before, I think my daughter - two

daughters, who are very good in English, would be very disappointed with me.

Q Do you deny - I'm not sure that I got a denial then. Do you disavow those statements today?

MS. EMERSON: Objection. Asked and answered.

JUDGE FINKLE: Overruled.

Q (By Mr. Coopersmith) You may answer the question.

A Okay. Let me try again. I guess you didn't understand that answer so let me try again. I deny that those are my words. But you said do I disavow the statements, and I guess I'd say, if you are asking is that word for word my statement, the answer is, it is not, so I therefore disavow it as being my words.

Q Are the statements attributed to you on page one of Exhibit 118, do they reflect your attitude at that time?

MS. EMERSON: At this time I would request that the witness be given time to peruse the article. He's being asked about specific statements in the context of a broader article.

JUDGE FINKLE: That would be fine.

MR. COOPERSMITH: We have no objection.

JUDGE FINKLE: Take the time you need.

A (Perusing.) Yes, I've looked at the article, the cover story.

Q (By Mr. Coopersmith) All right. Dr. Gollhofer, is it your

testimony that you never reviewed or approved the quotes attributed to you in Exhibit 118?

A That is my testimony.

Q And is it your testimony - do the quotes attributed to you in Exhibit 118 accurately reflect the opinions you held at the time?

A No, they do not.

Q Okay.

MR. COOPERSMITH: Your Honor, at this time the Intervenors ask that the testimony of this witness be adjourned and resumed later. The WSMA would have liked to have offered the testimony of another witness involved in the interviews that were given by this witness for authentication purposes.

MS. EMERSON: We would object, Your Honor.

JUDGE FINKLE: Go ahead.

MS. EMERSON: I mean clearly if there was - if there's an issue here about the information prepared in these reports prepared by the WSMA, they had ample opportunity to know who their witnesses were with respect to the authorship and the accuracy of the statements therein.

JUDGE FINKLE: Response?

MR. COOPERSMITH: Your Honor, we are prepared to present today if necessary the testimony from Mr. Perna, who is seated at counsel table, but the person who possesses

personal knowledge of interviewing Dr. Gollhofer, getting his review and approval for everything that appears in these publications, is available to us if necessary. For cost reasons we did not want to bring that person all the way down here if it would prove to be unnecessary, but we can certainly make her available, and we wish to do that.

MS. EMERSON: If I could respond briefly.

JUDGE FINKLE: I'm going to rule in your favor so you may not want to respond. I'm not going to adjourn Dr. Gollhofer's testimony; you can complete that examination. It's a separate issue of whether another witness may be called in this area. I'll hear from counsel before I rule on that. If by some chance, which I don't expect, it's necessary in your view to recall Dr. Gollhofer after further testimony, I'll consider that, although I'll remind counsel that, as we discussed, testimony in this proceeding, the notion was that all examination of a given witness would be completed upon his or her first appearance. So, with that guidance, please continue with your examination.

MR. COOPERSMITH: Okay. Thank you, Your Honor.

Q (By Mr. Coopersmith) All right. Let me ask you to read into the record, Dr. Gollhofer, on page one of the Exhibit 118 you will see a paragraph that begins with your name, "Dr. Gollhofer said," and that's in the second column on page one. Could you read that paragraph into the record?

MS. EMERSON: At this time we would object on the ground that there's been no basis for any reading of this document into the record. There's been no basis for any impeachment that's even been established here.

JUDGE FINKLE: Direct me to the exact --

MR. COOPERSMITH: Sure.

JUDGE FINKLE: Without reading it, exactly what are you going to ask him?

MR. COOPERSMITH: Thank you, Your Honor. We are looking at the paragraph that begins "Dr. Gollhofer." It's the second column. And the question - the impeachment here was on this witness's characterization of --

JUDGE FINKLE: I can read it for myself --

MR. COOPERSMITH: Okay.

JUDGE FINKLE: -- and I just need to make a judgment. Give me - is it that entire paragraph is what you propose to read or have him read?

MR. COOPERSMITH: That is correct.

JUDGE FINKLE: I'll permit this question.

Q (By Mr. Coopersmith) Could you read that into the record, Dr. Gollhofer?

A "Dr. Gollhofer said insurance CEOs refuse to acknowledge how unhappy patients are. 'Patients feel insurers are making medical care decisions by virtue of the roadblocks they create, the encumbrances they manufacture and the Rube

Goldbergian landscape that people have to navigate, just so their doctor can do the right thing,' he commented. 'I don't think the insurance CEOs get it'".

Q And just for accuracy sake, Dr. Gollhofer, there was a quote over the words "Patients feel insurers," is that correct, a quote mark?

A That's correct.

Q And a closed quotation mark - well, the exhibit will speak for itself on that. Could you then move to the next paragraph and read the second sentence of that paragraph into the record, please?

MS. EMERSON: We'd offer the same objection: no basis for impeachment or that the witness made these statements.

JUDGE FINKLE: Just give me a minute.

Q (By Mr. Coopersmith) If you can --

JUDGE FINKLE: No, no --

MR. COOPERSMITH: I'm sorry, I couldn't hear you, Your Honor.

JUDGE FINKLE: I read the one paragraph you directed me to and now I need to read this one as well.

MR. COOPERSMITH: Sure.

JUDGE FINKLE: You may proceed.

A Quote, "'Physicians are torn between their patients and the incredible hassles insurance companies are creating. They

don't want to hurt their patients, but the companies won't bargain with them,'" end quote.

Q (By Mr. Coopersmith) Thank you. And turning to page three of the exhibit. Actually, forgive me, that sentence starts at the bottom of page one and continues on to page three.

MR. COOPERSMITH: And anticipating the objection, Judge, if you could just read that sentence and see if it's permissible for the witness to read that into the record.

JUDGE FINKLE: I'll take that as the same objection and I will permit it.

MS. EMERSON: That's correct. Thank you.

A "That relationship may not improve any time soon, because insurers 'view physicians as interchangable and expendable,' he added."

Q Thank you. And Dr. Gollhofer, is it fair to say that Premera - there was no exception in those statements made for Premera; is that correct?

A Well, I think I said earlier those weren't my statements, but --

Q I understand. I'm just asking a simple question.

MS. EMERSON: I'll object.

Q (By Mr. Coopersmith) I'm not asking you to adopt the statement.

MS. EMERSON: I'll object. Lack of foundation and the document speaks for itself.

JUDGE FINKLE: Repeat the question.

MR. COOPERSMITH: Sure.

Q (By Mr. Coopersmith) The question is whether there was any exception made in those statements for Premera's conduct.

JUDGE FINKLE: Overruled, in that form.

MR. COOPERSMITH: Yes.

A So, you mean did the statements specifically mention Premera, is that what you asked?

Q (By Mr. Coopersmith) No. The question was whether - did those statements specifically exclude Premera?

A No, they did not.

Q Okay. And I'm turning your attention to Exhibit 117 again, which you have in front of you, and the response to the question "What is the source of these changes?" from page one, and the response to the second question is what the WSMA would like to have read into the record, Your Honor.

MS. EMERSON: And again, I would offer the same objections.

JUDGE FINKLE: I'm sorry, I'm just not tracking with you, about where exactly are you?

MR. COOPERSMITH: Sure. We are on Exhibit 117. We are on the first page. And we would like this witness to read into the record the replies to two questions, first question, "What is the source of these changes?" and then the next question follows immediately thereafter.

A "What is the source of these changes?"

JUDGE FINKLE: You need to wait for just one second.

MR. COOPERSMITH: In fact, Your Honor, let's just strike and go just to the first question, "What is the source of these changes?" just that response.

JUDGE FINKLE: Please go ahead and read it.

A "What is the source of these changes? Most of them have been made by insurers trying to control costs, but most of the changes so far simply seem to make healthcare delivery more cumbersome. Patients and physicians are united in feeling that insurance companies are making too many clinical decisions. Patients clearly want more control over their health care."

Q (By Mr. Coopersmith) Thank you. And on page four of that exhibit, the paragraph in the first column that begins "The basic message of CURE." And Dr. Gollhofer, if you could allow the judge to review the passage first.

JUDGE FINKLE: I'll assume the same objection and you can go ahead and read the paragraph.

A I'm not sure where we are.

Q (By Mr. Coopersmith) Okay. No problem. It is page four, first column --

A Yes. Oh, there it is.

Q Okay. So just that paragraph.

A "The basic message of CURE is that managed costs are not conducive to good medical care, that insurers are making too many medical decisions, and that the system is downloading numbing expenses on physicians that add no value to patient care."

Q Thank you. And with respect to those two statements, is it true that no exception was made for Premera's conduct?

A That is true.

Q Okay. Turning to the question of payment to physicians for their medical services. You said in your testimony today that, quote, Provider payments are determined by market forces, closed quote. Is that correct and you said that in your written testimony?

A Sorry --

Q We are done with that exhibit for now and we are turning to the issue of payment to physicians for the medical services they provide.

A Okay.

Q And in your written testimony and in your responses to your attorney today you said, quote, That provider payments are determined by market forces, closed quote. Do you stand by that statement?

A Yes, I do.

Q Okay.

JUDGE FINKLE: About how much longer do you expect

to be?

MR. COOPERSMITH: Fifteen minutes.

JUDGE FINKLE: We'd better take a break at this point, 15 minutes.

(Recess taken.)

JUDGE FINKLE: Please continue when you are ready.

MR. COOPERSMITH: Thank you.

Q (By Mr. Coopersmith) Dr. Gollhofer, are you ready to resume your testimony?

A Yes, I am.

Q Great. Thank you. I'm showing you what has been marked as Exhibit 119. And have you had an opportunity to review that?

A Yes, I have, the first two pages.

Q Great. And can you identify what Exhibit 119 is?

A It is the WSMA Membership Memo, March 3rd, 2000.

Q And does it appear to be an accurate copy of that memo to you?

A It does.

Q And can you identify what a WSMA Membership Memo is?

A The WSMA Reports was - I would say was our sort of formal newsletter, the Membership Memo might have been sent out in between reports - WSMA Reports publication times for additional communication of the membership.

Q And the Membership Memo, like the WSMA Reports, goes out to the entire membership of the WSMA; correct?

A Yes.
Q And in fact, it probably has a circulation beyond just the membership; is that correct?
A I don't know.
Q Okay. And does your name appear on the Membership Memo in Exhibit 119?
A It does, "John D. Gollhofer, MD, President."
Q All right. And did you review and approve the contents of this Membership Memo?
A No, I did not.
Q Is it your testimony that you did not see - well, let's turn your attention to the section on page one called "Here are the facts." Is it your testimony that - well, why don't you read into the record, please, numbers one and three.

MR. COOPERSMITH: And do we do the round of objections again?

MS. EMERSON: Your Honor, we would object on the same grounds.

MR. COOPERSMITH: And it's one and three, Your Honor, and then just for expediency sake, it will be number one in the next section on page two, "In analyzing these facts."

JUDGE FINKLE: Overruled. You can go ahead, please.

Q (By Mr. Coopersmith) So Dr. Gollhofer, would you please read

numbers one and three on the first page?

A "The WSMA's sixth annual survey of health plans' payment methods shows that plans have engaged in some creative "gaming" of the RBRVS methodology in recent years."

Three: "By varying both the RBRVS Relative Value Units and the conversion factors from year to year, plans can obfuscate the resultant changes in their payment amounts to physicians."

And then the next was item one on the next page?

Q Correct.

A "Health plans shouldn't "game" RBRVS payment methodology. Clear and above board disclosure of payments amounts would help diminish the climate of distrust between physicians and health plans."

Q And did that opinion accurately - rather, did the statements you just read into the record accurately reflect your opinion at the time?

A I think to a certain degree.

Q To what degree?

A Well, again, the words aren't mine, which makes it difficult to respond.

Q I'm asking if you agree with the statement expressed there.

A Well, there are three statements expressed.

Q Do you believe that the health plans were gaming the payment methodology for physicians?

MS. EMERSON: I'll object, as it mischaracterizes the document. The document appears to reflect some survey that was made and not the witness's own views or his own input into the survey.

MR. COOPERSMITH: That's what the question is.

JUDGE FINKLE: I take that as a question not about the document but directed to the witness itself.

MR. COOPERSMITH: Thank you, that's correct.

JUDGE FINKLE: If you understand the question.

THE WITNESS: I don't.

JUDGE FINKLE: Then please repeat it.

MR. COOPERSMITH: Thank you, Your Honor.

Q (By Mr. Coopersmith) Is it your belief that the health plans were gaming the payment methods for physicians?

MS. EMERSON: And again, I'm going to have to object here because this is just - this is improper form of impeachment. There's been no basis for any impeachment that's been established.

MR. COOPERSMITH: On - did I interrupt? On the contrary, Your Honor, just prior to the break the witness said that he stood by his statement that provider payments are determined by market forces. And this statement certainly appears to contradict that statement.

MS. EMERSON: Again, Your Honor, I have to object because this is reflecting the survey. The survey does not

go to this particular witness's own views of his statements.

JUDGE FINKLE: That's why I wanted to clarify that the question was directed to the witness and not intended to be directed to the survey finding. The question will be allowed.

MR. COOPERSMITH: Thank you.

A So the question - tell - repeat the question one more time.

Q (By Mr. Coopersmith) Sure. Do you believe that health insurance plans were gaming the payment methods that they used to pay physicians for the medical services they provided?

A I was told that that was happening. I had no direct knowledge of that.

Q And my question is whether you believed that at the time these statements appeared?

A I don't recall precisely what I believed in regard to that specific item at that time.

Q And do you disavow that belief now?

A Do I disavow --

Q I'll withdraw my question. Let me ask you this. Do you disavow the statements - did you disavow at the time the statements that appeared in March 2000 in the Membership Memo?

MS. EMERSON: I have to object. That mischaracterizes the record and his testimony. The document

reflects a survey. The document does not reflect this witness's personal views.

JUDGE FINKLE: Sustained.

Q (By Mr. Coopersmith) Okay. Let me rephrase the question then, since I obviously didn't make it clear to anyone in the room.

Did you at the time these statements appeared in March of 2000 disapprove these findings and the wording that was - that appears in this Membership Memo?

MS. EMERSON: Again, this mischaracterizes the record.

JUDGE FINKLE: Sustained. It's different from the previous, which purported to be his own statements.

MR. COOPERSMITH: Correct.

JUDGE FINKLE: I would permit those, but these are not representations of his views.

MR. COOPERSMITH: That is correct. And Your Honor, let me try one more time then.

Q (By Mr. Coopersmith) This question is just aimed at whether you adopted or rejected the survey findings that appeared in the Membership Memo at that time.

A Whether I personally adopted or rejected the survey findings?

Q Correct, exactly.

A I didn't do either.

Q Okay. Moving on. Is it your belief that reduced

reimbursement for physicians makes it harder for physicians to deliver quality care?

MS. EMERSON: I'll just object. "Reduced," vague and ambiguous. Reduced as to what?

JUDGE FINKLE: If you understand the question well enough to answer it, go ahead.

A Physician reimbursement almost certainly determines physician practice behaviors. So I can postulate that if a physician practice was being squeezed in terms of its costs versus its income, that practice might be driven to see more and more patients, and that could - I can postulate a scenario where seeing more and more patients might adversely affect quality.

Q (By Mr. Coopersmith) All right. I'll approach you and show you what will be marked as Intervenor's Exhibit 120.

Do you recognize what's been marked as Exhibit 120?

A WSMA Membership Memo, December 17th, 1999.

Q And does your name appear anywhere on that?

A Yes, it does.

Q And did your name appear on these Membership Memos throughout your tenure as president of the WSMA?

A I believe it did.

Q And turning your attention to the last paragraph on page one, could you review that and then let the judge determine whether or not he'll allow you to read that into the record?

JUDGE FINKLE: Are you talking about the last full

paragraph on page one?

MR. COOPERSMITH: Yes, Your Honor, that begins "While the effort."

JUDGE FINKLE: Go ahead.

MS. EMERSON: Your Honor, just for the record I would object. I fail to see what this is impeaching. There's been no foundation or no grounds for impeachment that's been established with this particular untimely document.

JUDGE FINKLE: Go ahead.

A "CURE To Train Focus on Sinking Healthcare Delivery Ship. While the effort on CURE's 2000 legislative agenda is just beginning, plans for 2000 include focusing public and legislative attention on the deteriorating healthcare marketplace and economic jeopardy facing physician practices across Washington. Health insurance company market consolidation, rising insurance premiums, and declining physician reimbursement bode ill for the sort of health care our patients want and expect."

Q (By Mr. Coopersmith) And did you review and approve that statement before it was published in the Membership Memo?

A No, I did not.

Q And did you stand by that statement - did that accurately reflect your opinions at that time?

A The opinions expressed in all of these documents are the

policy positions of the WSMA at that time.

Q And you were the head of the WSMA at that time. And my question was whether this particular statement accurately reflects your views at that time?

A And I believe I responded, but I'll respond again. All of these documents have expressed the public policy position - or sorry, I'd say even the internal policy position in terms of the memos, of the WSMA. As president and member of the executive committee, I and the other members of the executive committee would have been busy setting those public policy positions. So I'm sure to a certain extent they reflect my opinions at that time. But is this - were all of these documents - did the executive committee reflect only my opinion? The answer is no, it reflected the opinions of all of the members of the executive committee. The policy is set by the annual meeting of the House of Delegates. WSMA sets policy in general. Periodic quarterly meetings of the board of trustees refines that policy. Monthly meetings of the executive committee further refines and implements that policy.

Q So by the time that policy is issued, it reflects an internal process by the WSMA; is that correct?

A That's correct.

Q And that would be an extensive internal process; is that correct?

A I guess so. I mean as extensive as you can be meeting once a month.
Q Okay. And when - these policy statements that were issued under your name, did you get vigorous disputes about the characterization of health plans, including Premera, by your members?
A Vigorous disputes, I don't know what that means.
Q Did you have lots of members calling you or coming up to you in person and saying, I don't think you've been fair to the health plans or I don't think that you have been fair to Premera in particular?
A No, I did not.
Q Okay. Then moving on to the conversion itself. You testified that you didn't believe the conversion would have any adverse impact; is that correct?
A That's correct, but I - I mean it was on various topics, provider pay, access, but yes --
Q Rural healthcare?
A Correct.
Q Correct? All of those issues; right? And you didn't think that conversion would affect the physician reimbursement one way or another; is that also a statement of yours?
A That's correct.
Q Okay. And is it your opinion that Premera is the dominant purchaser of physician services in Eastern Washington?

MS. EMERSON: I'll object to the term as vague.

Q (By Mr. Coopersmith) Are you confused about the question?

A Yes.

Q All right. Do you not - what part are you confused about, Mr. Gollhofer - Dr. Gollhofer?

A So, in terms of purchaser --

Q Correct.

A -- I guess I'd say contractor maybe. I'm not sure they purchased my services. I'm not trying to split hairs but I didn't quite understand that. And the dominance is what I really didn't understand.

Q Okay. What do you understand the term dominant to mean?

A Dominant: Powerful, forceful, able to exert its will.

Q And do you believe that that accurately describes Premera's activity in the healthcare marketplace in Eastern Washington?

A No, I don't.

Q And do you believe that Premera contracts with more physicians than any other health insurance company in Eastern Washington?

A I don't have any factual basis to respond. I don't know. I assume they do. I think they have the broadest network, but I don't know compared to other providers.

Q All right. Let me show you what will be marked Exhibit 121.

Can you identify what Exhibit 121 is?

A Yes, I can. WSMA Membership Memo, October 22, 1999.

Q And again, your name appears on it; is that correct?
A Yes, it does.
Q All right. The passage in question would be the first paragraph and then the first statement in the resolution, which is I guess the next paragraph, that "you immediately halt."

MR. COOPERSMITH: I assume we have the same objection from opposing counsel so, Your Honor, that's what the WSMA would like this witness to read into the record.

MS. EMERSON: Again, Your Honor, we do object. There's been no basis for impeachment that's been established and, again, we would object on untimeliness grounds as well.

JUDGE FINKLE: Sustained.

MR. COOPERSMITH: Your Honor, as to which ground did you sustain the objection?

JUDGE FINKLE: The grounds except for untimeliness. It was proposed as impeachment, and I do not believe that it impeaches his testimony.

Q (By Mr. Coopersmith) Did you believe that Premera was the dominant carrier in Eastern Washington during the time in question, at the time this was written in 1999?
A In October 1999, I'm hard-pressed to remember what I believed necessarily. Maybe if you could rephrase the question.
Q The question was whether you believed that - let me back up.

Dr. Gollhofer, you've practiced all of your career in

Washington State, in Eastern Washington; correct?

A Yes, I have.

Q Twenty-six years --

A No, no. Fourteen years, since 1990.

Q Right. And at the time nine years?

A At the time nine years, correct.

Q And you had - had you been the head of the Spokane Medical Society at that time?

A I had by that time, yes.

Q Now you are the head of the largest statewide organization at the time of this memo?

A That's correct.

Q And are you saying that you don't recall whether you thought Premera was the dominant carrier in Eastern Washington at that time?

MS. EMERSON: Objection. Mischaracterizes his prior testimony.

JUDGE FINKLE: I take it as a current question.

MR. COOPERSMITH: Correct.

JUDGE FINKLE: Do you understand the question?

THE WITNESS: Well, yes, I do. I mean I've defined dominance, and I'm not sure I would necessarily apply that to a health plan. Did I believe that Premera had the majority of commercially insured patients in Eastern Washington at that time? The answer is yes.

MR. COOPERSMITH: Your Honor, based on the witness's answer, we now ask that that statement be read into the record.

MS. EMERSON: Same objection: There's been no basis established for impeachment. It's not --

MR. COOPERSMITH: And the witness just said he didn't believe that the carrier was dominant.

MS. EMERSON: That mischaracterizes his testimony.

JUDGE FINKLE: I don't accept that. Objection sustained at this time; I don't believe it was accurate. So go ahead.

MR. COOPERSMITH: If I may, could I have the court reporter read the witness's response on dominance that was just two questions ago.

(Reporter perusing notes.)

MR. COOPERSMITH: Actually, in the interest of time, let's move on. Thank you, Madam Court Reporter.

Q (By Mr. Coopersmith) Dr. Gollhofer, can you tell us whether in your opinion if a carrier did have a large presence in the health insurance market in a particular part of the state, would that have the tendency to interfere with a physician/patient relationship?

MS. EMERSON: I'll object. Vague and ambiguous and lack of foundation.

JUDGE FINKLE: Overruled. If you understand it,

please answer.

A If you could repeat it.

Q (By Mr. Coopersmith) Sure. In your opinion, Dr. Gollhofer, if one health insurance carrier had a large percentage of a particular health insurance market, could that interfere with a patient/physician relationship?

A Potentially, depending on the behavior of that carrier.

Q And could that interfere with clinical decisions made by the physician?

A Potentially, depending on the behavior of the carrier.

Q And could that large percentage of the market, if it were in Eastern Washington, also have an impact on care for rural residents of our state?

A Potentially, depending on the behavior of the carrier.

MR. COOPERSMITH: No further questions of this witness at this time.

JUDGE FINKLE: Are there from other Intervenors?

MS. HAMBURGER: No.

JUDGE FINKLE: Direct?

MS. EMERSON: Yes, briefly, Your Honor.

(Continued on next page.)

REDIRECT-EXAMINATION

BY MS. EMERSON:

Q Dr. Gollhofer, in late 1999, the early part of 2000, up to let's say February, about the time of the WSMA Reports that we reviewed as Exhibits I-118 and 119, can you tell us what was the WSMA's policy vis-a-vis health plans in Washington in general?

A WSMA policy at that time vis-a-vis health plans in general was to be highly critical, to find fault, and to try to exert leverage to achieve the desires of the House of Delegates. My recollection has been a number of resolutions passed. And I think - for instance, there in this I-121, that was the second paragraph, if I can refer to that, Mr. Commissioner?

COMMISSIONER KREIDLER: (Nods head.)

A Second paragraph it actually quotes the Resolution C-22 from the House of Delegates of that year, 1999. So in other words, that's how you would set - that's how the WSMA would set policy. And then the board of trustees and the EC would be responsible to implement those policies. And the feeling in the trenches in those days was very negative towards health plans.

Q (By Ms. Emerson) And did you personally set the direction for the WSMA in late 1999 and early 2000?

A No, I did not.

Q Who set that policy?
A The board of - the House of Delegates set the policy, and the board and the EC implemented that policy. But understand that the House of Delegates only meets once a year so there could be times that the board of trustees had to make some decisions policy-wise in the interim.
Q So, with respect to the pieces that were written in the WSMA Reports, whose - that were attributed to you, whose views were those?
A As I stated... These documents were meant as a tool to use to try to help implement the policy of the WSMA. The documents are written essentially by staff to try to further that - the implementation of that policy. Now, when the executive committee would meet on a monthly basis, we would debate and discuss various issues. For instance, the CURE campaign, I remember we spent a lot of time trying to talk to the CURE campaign, and a public relations firm was hired. We did this in conjunction with Physicians Insurance, who gave us a monetary grant to do that. So in other words, I'd say this was a process that resulted in a public political position taken in order to achieve some end.

And again, while I'm not disavowing any of these issues, I'm not disavowing having participated in the discussion regarding these issues; I'm simply saying, in honesty, those weren't my words. But was I present when these sorts of

approaches were determined? Absolutely. Clearly that was the WSMA approach at that time, to be very hostile towards health plans. I guess we thought it would net us some benefit.

Q And did you hold some or all of those views at the time, back in late 1999, early 2000?

A Held some, but certainly nobody held all of the views of the entire organization. That's what an organization is all about.

Q Do you hold those views now?

A The views specifically referenced, no. I've changed my mind.

Q You testified previously that at one point in time when you were the president of the WSMA, that Dr. Castiglia of Premera contacted you, reached out to you. When did that occur?

A It was sometime during legislative session. I suspect it was probably in March. I remember the weather was sunny and warm so I suppose it was in March, or maybe April if it went that long that year, I can't remember.

Q And of what year?

A Of 2000.

Q And you testified previously that following up on that initial contact that was made by Dr. Castiglia, that as the president of the WSMA you had subsequent dealings with Premera in your official capacity; is that right?

A That's true. Again, just to set it in context, I was the

spokesman for an organization that was highly critical of health plans, and when Dr. Castiglia called me I was a little bit uncomfortable, I have to say. I sort of - I wasn't going to refuse to meet with him, but I thought he might really take me to task on the things I had been saying about him. You know, the - what's that famous line from the movie? Who are all these people and why are they saying all these terrible things about me?

I guess it was a little uncomfortable. Maybe that's why I asked Jeff to sit in on the meeting. In any case, when Dr. Castiglia just opened up his notebook and said what can I do to make this right, I was really kind of surprised and pleased. We sat there for probably an hour and gave him a whole multiple-page list of things we'd like to see him change, and to my knowledge he started working on that. Because certainly Premera is a different organization now I guess than it was then. I don't know that for a fact. But certainly I think in those days there was still pre-authorization. And that's gone.

So I guess a long way of saying that I think that Premera did respond favorably to those statements. And again, certainly as I've worked with Premera I realize they are doing everything they can to fix the issues and the problems that we have.

Q And how do you characterize Premera's commitment today to

wanting to work on provider relations or not?

A Based on my activity on the board and the quality committee, dealing with our medical director staff, they are highly committed to working with physicians. They want to have a good relationship with physicians. That's a lot of the dimensions platform that was established, so that there would be the connectivity and all the other improvement of transactional issues that physicians have been asking for.

Q And finally, Dr. Gollhofer, you were referred in Exhibit I-118 to a passage referencing that "Patients feel insurers are making medical care decisions by virtue of the roadblocks that they create, the encumbrances they manufacture and the Rube Goldbergian landscape that people have to navigate, just so their doctor can do the right thing." Where do you think Premera is today vis-a-vis the references made in this document about the roadblocks and encumbrances that are attributed to health plans such as Premera?

A From my standpoint as an obstetrician/gynecologist, I can say that the patient comes in, gives me her history, I do the exam, we get the diagnoses, we talk about the treatment options. If the treatment option that she then decides on is an expensive one, if she has Premera there's never a problem, they just go out and get scheduled for the surgery. There's another plan that I provide for that requires a number of

hoops that have to be jumped through by the patient and the patient's scheduler before the patient can actually be scheduled. So I'd guess I'd say no, compared to this other carrier I deal with, Premera has none of these roadblocks. I'm not accusing the other carrier of being Rube Goldbergian, but again, I don't believe Premera has any roadblocks to the care that I try to render.

Q Thank you, Dr. Gollhofer.

MS. EMERSON: No further questions.

MR. HAMJE: We have no further questions.

MR. COOPERSMITH: Mercifully briefly.

RECROSS-EXAMINATION

BY MR. COOPERSMITH:

Q Dr. Gollhofer, did the Premera executive that you met with back in the spring of 2000, did he go back to the company, to your knowledge, and then lower Premera's premiums?

A Did Dr. Castiglia lower Premera's premiums?

Q Right, after meeting with you and Dr. Collins?

A I doubt that he did.

Q Okay. And did the Premera executive go back and raise the amount that Premera pays for medical services after he met with you and Dr. Collins?

A I know that Premera's compensation of physicians has gone up every year. What was the time frame relation of that meeting and was it as a result of that meeting, I don't know. I doubt it, but I don't know.

Q Okay. And then did the Premera executive go back and decrease Premera's market share in Eastern Washington after you met with him?

A I doubt that he did.

Q And is it your opinion that Premera's reimbursement policies have changed significantly since the spring of 2000?

A Define what you mean by policies.

Q Its reimbursement practices, the amount it reimburses physicians, has it changed dramatically since 2000?

A You need to rephrase that question. You asked --

Q Has Premera dramatically improved the amount that it pays physicians since 2000?

A Premera has increased the amount it pays physicians since 2000. Dramatically is an adjective that I don't know how quite to define.

Q In comparison with your understanding of the operating costs of a practice.

A Now I really don't know what you mean.

Q All right. Has Premera lowered its premiums, to your knowledge, since 2000, the premiums it charges its members?

A I believe the premiums have gone up since 2000.

Q Okay. And has Premera reduced its market shares in Eastern Washington since 2000?

MS. EMERSON: I'll object. Lack of foundation.

JUDGE FINKLE: Sustained, unless you can demonstrate that he has such foundation.

Q (By Mr. Coopersmith) Has Premera reduced its presence in the market in Eastern Washington since 2000?

MS. EMERSON: Same objection, and also vague and ambiguous.

JUDGE FINKLE: You can ask about his personal knowledge, and then otherwise you'll need to establish a better foundation.

Q (By Mr. Coopersmith) Okay. Dr. Gollhofer, in your opinion, has Premera's share of the contracts between physicians and insurance companies in Eastern Washington gone up or gone down since 2000?

MS. EMERSON: Same objections.

JUDGE FINKLE: You need to refer to his direct experience or his direct knowledge, for example, his own practice, not all of Eastern Washington, without further foundation.

MR. COOPERSMITH: Okay. Thank you, Your Honor.

Q (By Mr. Coopersmith) In your experience, in your clinic and in your particular practice, has Premera's portion of your payer mix gone up or gone down since 2000?

A I can't answer for the clinic. I'll make - I'll answer for my practice. As far as I understand it. What I mean by that is, I don't always know what insurance a patient has. It's on the chart slip. I will always look at it if I'm going to schedule a procedure, but otherwise not necessarily. But I would say I have a sense of the patients that - who's insuring the patients that I'm seeing. And it's just a sense. My sense is that - and I almost hate to say this because you are probably going to misinterpret it. My sense is it may have gone down a little bit in my own personal practice because I think I'm seeing personally more Group Health and Asuris and maybe a little less Premera. But I don't know that that has any generalization to the rest of Eastern Washington.

Q Thank you for your time, Dr. Gollhofer.

MR. COOPERSMITH: No further questions.

MS. EMERSON: Just briefly.

REDIRECT-EXAMINATION

BY MS. EMERSON:

Q Dr. Gollhofer, you testified about your meeting with Dr. Castiglia in which Dr. Collins was present as well, and the follow-up meeting with Premera management. In those

meetings, what concerns - what provider concerns, if any, do you recall sharing with either Dr. Castiglia or with Premera management?

A I don't recall the specific concerns, but I'm sure the concerns that the organization - when we met with Dr. Castiglia, I would have referenced the organizational concerns. When I met with the Premera management, I don't know if I was still past president or if I was not. See, once I'm off the executive committee, I can express my own views, but if I'm still on the executive committee I have to express those views that represent - I'm representing the organization, I have to express those views. And again, I don't know when that second meeting came.

The first meeting I'm sure we told Dr. Castiglia we had a concern regarding reimbursement, regarding authorizations, regarding retroactive denials, regarding promptness of payment, regarding appeal for denial, all those things that went with managed care in the bad old days. So I'm sure it would have been a whole long, multi-page list of those concerns. And again, as I say, fortunately those are gone because Premera doesn't do managed care anymore, thank heavens.

Q At the time did Premera seem genuinely interested in what you had to share?

A Yes, they did, very genuinely interested. And I was very

impressed with Dr. Castiglia. He in fact then was - he would periodically travel to Eastern Washington, and one of the times he was there he called and asked if we could meet. And actually Dr. Watts (phonetic) and Dr. Castiglia and I met at my house and we had a discussion again. Dr. Watts filled him in also about the problems and concerns that we were having as practitioners there. And again, I think even Mr. Ancell came over at some point also to ask how possibly he could improve the situation. I don't remember the time frame, forgive me.

Ultimately, when I was invited to speak with Premera management, again, I felt a little - I didn't know quite what reception I would get. And I really did express all of those same - similar sorts of issues. My sense was the managers listened politely, there was interaction, there were questions that I thought were appropriate, and afterwards there was a reception, and I felt that there wasn't certainly any animosity on their part.

Q And have you seen Premera respond to those concerns that you initially articulated back in 2000?

A Yes, I have. I mean all of these issues that we are talking about here have gone away. Premera has - and I won't say they went away because of what I said to Dr. Castiglia. But I will say that Premera is I believe smart enough to understand that managed care is not something that customers

want, it's not something that patients like, it's not something that providers like, and it's gone.

Q In those meetings with Dr. Castiglia or with Premera management, did you express concerns about Premera's market share?

A Never.

Q Did you express concerns about Premera's premiums?

A No, I didn't.

Q Thank you, Dr. Gollhofer.

MR. HAMJE: No questions.

MR. COOPERSMITH: No questions.

JUDGE FINKLE: Thank you, please step down.

COMMISSIONER KREIDLER: (Indicating.)

JUDGE FINKLE: Oh, I'm sorry.

THE WITNESS: Overruled, Your Honor.

CROSS-EXAMINATION

BY COMMISSIONER KREIDLER:

Q At the time - Dr. Gollhofer, at the time those articles appeared in January and February of 2000, were you aware that there was significant dissatisfaction among physicians with carriers, including Premera?

A Yes.

Q I'm curious, when you met with the medical director of Premera, were you still the president when you first met with him?

A I believe I was.

Q And --

A Yes. Yes, I was.

Q And you were still on the board for another year after you were president, as immediate past president?

A That's correct, the executive committee.

Q Executive committee. I'm curious, relative to the survey that you reported that the - Premera and LifeWise physician satisfaction survey that was presented to your Premera quality committee, when that survey was conducted was it conducted in any way that physicians who participated could be identified or perceived, or was there any potential they could be perceived and identified in responding to that survey?

A It was done by an outside company, it wasn't done by internal Premera personnel, so I would - so I'm sure there's really no way those physicians were identified to Premera. But could the respondents have since then? I suppose they could have. I believe it's an on-line survey that you either do it by telephone or on the computer, and who knows how you can be tracked of course electronically.

Q The reason I ask is because I would think that the

independent response to a satisfaction survey with the health carrier would be somewhat tempered if there was ever the perception that the health carrier could know what your responses were, and if they were perceived as excessively negative, that there could be repercussions. Whether there would be or not, would not be the issue as much as there could be that perception. And that it would condition how you would respond relative to your satisfaction with that particular carrier.

I'm asking, for the best of your knowledge, there was no connection is your reply, there was no way that physicians could be tracked, and that you are uncertain as to whether physicians might not have perceived that that kind of tracking could take place?

A That's correct.

Q Thank you very much.

MS. EMERSON: If I could just offer, Commissioner Kreidler. Brian Ancell, who is the executive vice president responsible for the area in which the survey was conducted, he will be able to provide additional information on the survey.

COMMISSIONER KREIDLER: And he's on the witness list?

MS. EMERSON: He is on the witness list.

COMMISSIONER KREIDLER: Great. Thank you.

JUDGE FINKLE: Any follow-up to the commissioner's questions?

MR. HAMJE: None, Your Honor.

MR. COOPERSMITH: I think, Your Honor, we would like to just introduce one more exhibit. We won't have any questions about it, just introduce it.

JUDGE FINKLE: Sure, have it marked.

MR. COOPERSMITH: Other than to get the witness to identify it for us. We are up to 123; is that correct?

MS. THOMAS: Two.

JUDGE FINKLE: You can have it marked and I'll hear any objection. I'm never going to stop anyone from marking things.

RECROSS-EXAMINATION

BY MR. COOPERSMITH:

Q Dr. Gollhofer, I've just handed you what has been marked as Intervenor's Exhibit 122, and the passage in question is on the first page, first column, and it's halfway down the third paragraph. It begins "WSMA President John G. Gollhofer."

A (Perusing.)

JUDGE FINKLE: Is there a question?

MR. COOPERSMITH: Yes. I was waiting for --

JUDGE FINKLE: I've read the passage.

Q (By Mr. Coopersmith) Okay. And the question first is, 122 is the WSMA Reports from September of 2000; is that correct?
A Yes.
Q Okay. And you met with the Premera executive in April of 2000; is that correct?
A Oh, yes. Dr. Castiglia, yes, yes.
Q Thank you.

MR. COOPERSMITH: No further questions.

MS. EMERSON: Again, I'm going to just object to the previous line of questioning. First of all, it was improper rebuttal. This is not even reflecting an article about Premera. This is about a potential Regence affiliation or alliance, so --

JUDGE FINKLE: I haven't admitted it and so it's - there's nothing, in a way, to object to, I don't think. It's been identified and no reference in testimony made to it, so I don't think there's anything before me right at the moment.

MS. EMERSON: Your Honor, I'm just objecting to the line of questioning as being improper.

JUDGE FINKLE: Okay. I'll overrule the objection. I don't think there was anything substantive.

Anything further from anyone?

MR. HAMJE: No, Your Honor.

COMMISSIONER KREIDLER: No.

JUDGE FINKLE: Please step down.

(Witness excused.)

MR. KELLY: Next witness?

JUDGE FINKLE: It's 4:35. What's your pleasure? You've got 25 minutes to work with.

MR. KELLY: Well, I guess it depends on how long the cross is going to be. This is Donna Novak.

JUDGE FINKLE: We don't necessarily need to complete the cross. If everyone wanted to adjourn, I'm willing to listen, subject to what the commissioner would like to do. I'm also prepared to proceed until 5:00 or shortly after.

MR. KELLY: I think we can proceed, if that's okay with you.

JUDGE FINKLE: Let's go ahead then.

MR. KELLY: We've got to get organized.

JUDGE FINKLE: Okay.

(Briefly off the record.)

MR. KELLY: Please come forward, Ms. Novak.

DONNA C. NOVAK, having been first duly sworn by the Judge, testified as follows:

JUDGE FINKLE: Please be seated.

(Continued on next page.)

DIRECT EXAMINATION

BY MR. KELLY:

Q Would you state your full name for us, please.

A Donna Carolyn Novak.

Q Could you identify your company and your position in it?

A Yes. I am the president and CEO of NovaRest, Inc. It's an actuarial management consulting firm that has been formed to provide cost effective consulting to regulators and to insurance companies.

Q And what's your business address?

A My office is at 980 Eastshore Drive, Suite 100, in Fox Lake, Illinois. Zip is 60020.

Q Okay. That's good for our record. Thank you.

Could you tell us your educational background, please.

A Yes. I received a bachelor's in mathematics in 1972 from De Paul University. I did post-graduate work in mathematics from Illinois Institute of Technology. And I have an MBA in finance and healthcare administration from Kellogg, which is the Business School of Northwestern University.

Q Are you also an accredited actuary?

A Yes, I am.

Q Would you explain that, please.

A Okay. I am a member of the academy - American Academy of Actuaries, MAAA. I'm also a fellow of the Conference of

Consulting Actuaries. I'm an associate of the Society of Actuaries.

Q And do you take continuing education programs each year to meet your requirements of those associations?

A Yes, I do, and for the requirements to sign actuarial opinions, and so we have an annual requirement for continuing education.

Q Have you been active with the Academy of Actuaries and its various undertakings?

A Yes, I've been very active with the Academy of Actuaries. I was vice president of financial reporting for two years and therefore on the board. I do a lot of volunteer work for the Academy of Actuaries on a number of projects that I participate in and lead. The types of projects, for instance, were advice to congressional staff when they were formulating HIPAA, Health Insurance Portability and Accountability Act, testimony to the Medicare Commission when they were considering adding prescription drugs to Medicare. I participated in the team that reviewed the Medicare risk adjuster when it was proposed and reviewed by the academy back then. And numerous other projects.

Q Okay. Are you a member of any other professional organizations?

A Yes. I'm a Fellow of the Life Management Institute. And I am also an Associate of the - Health Insurance Associate.

Q Now, you indicated that you do work for both regulators and insurers. Let me ask you to give, if you would, some examples of the work that you have done for insurance commissioners and regulators.

A Okay. Most of my work recently has been for insurance regulators. For example, I would advise the Department of Insurance and Securities Regulation, DISR, in Washington D.C., in conjunction with the Form A filing. When the Blue Cross/Blue Shield of D.C. had the business affiliation with Blue Cross/Blue Shield of Maryland to form the not-for-profit holding company CareFirst, then I further advised the attorney general in Delaware when the Delaware Blue Cross/ Blue Shield company joined the CareFirst organization.

I was hired by the department - DISR in D.C. again to advise them when the CareFirst organization, which their plan was a member of, was going to go for-profit and be purchased by WellPoint.

And then I advised the Vermont Department of Insurance and Banking as part of the demutualization of the Vermont...

Q Now, I think we'll use the term perhaps NAIC, the National Association of Insurance Commissioners, did you have a role in developing a manual used by the NAIC?

A Yes. The NAIC hired my firm to write the financial analysts manual that they - the financial analyst and the state regulatory...

Q Have you done any other projects involving the NAIC?
A Quite a few in my role as a volunteer with the Academy of Actuaries. I led a project to write the first grant of the Health Reserve Guidance Manual that is used. I participated in a very major role in the development of the Managed-Care Organization Risk-Based Capital, which is currently Health Risk-Based Capital. And I've advised them, as well as regulators, on the effects of health insurance regulation. I do a lot of work estimating the effect of health insurance regulation on the marketplace.
Q Okay. Could you describe some of your experience in the field of capital requirements and sources of capital for health insurers?
A I would say that started when I was with Blue Cross/Blue Shield Association. I was with Blue Cross/Blue Shield Association from 1973 to - I'm sorry, 1993 to 1997, which was an interesting time. At that time the Blue Cross/Blue Shield Association had the capital benchmark formula, and they - it was only the Blues at that time that had a capital requirement for their plans.

Then I participated as a Member of the Academy of Actuaries team, as I said, in the development of the Managed-Care Organization Risk-Based Capital, was developed by the Academy of Actuaries. It was adopted after some revisions by the National Association of Insurance

Commissioners.

I've also advised clients on the strategic use of risk-based capital when looking at their strategies. I have helped a number of organizations determine what their risk-based capital should be and how to improve their risk-based capital.

Q While you were at the Blue association, did you have any role in actually going out to associations to evaluate their RBC?

A Yes. My primary role when I was at the Blue Cross/Blue Shield Association was working with Blue Cross/Blue Shield plans that were in financial problems according to the Blue Cross/Blue Shield Association benchmark, capital benchmark at that time, and to monitor the plans' improvements up until the point where it was again off of the early warning or the monitoring.

Q Since having left the Blue association, have you had occasion to serve as a consultant on RBC-type problems or issues for Blues?

A As I mentioned, I've had a couple of clients, including Blue Cross/Blue Shield plans, where I've advised them on their capital requirement and how to improvement their RBC ratios.

Q That was just three years - four years, I guess, of your career. Could you just give us a brief summary of the other types of activities you had during your course of employment?

A My career, I've been in this business over 30 years. I think my 35th anniversary is this fall. I've really been privileged to work in a number of different aspects with regulators and insurers. I've worked for three insurance companies. I've worked for CNA Financial. I worked for Trustmark. And I've worked for Bankers Life and Casualty.

I've done primarily consulting in recent years. A majority of my work has been in consulting. I've worked, for example, for Deloitte & Touche. I've worked for William M. Mercer, and now have my own consulting firm, which I've had for a couple of years.

Q Now your pre-filed direct testimony has been served and filed in this proceeding. Do you adopt that testimony?

A I do.

MR. KELLY: And Ms. Novak's pre-filed direct, Commissioner, has been marked as Hearing Exhibit P-65, and her curriculum vitae has been marked as P-66. And with her adoption of the testimony, Premera now moves to admit those exhibits.

MR. HAMJE: No objection.

MR. COOPERSMITH: No objection, Your Honor.

JUDGE FINKLE: Admitted.

(Exhibits P-65 and P-66 admitted.)

Q (By Mr. Kelly) And you submitted an expert report in this

proceeding, have you not?

A I did.

Q And I believe it is Hearing Exhibit P-67. It's entitled The NovaRest Report, entitled Capital Requirements and Sources of Capital, dated November 10, 2003. Is that your report and do you adopt it?

A That is my report and I do adopt it.

MR. KELLY: Then I would move the admission of P-67 as well.

MR. HAMJE: No objection.

MR. COOPERSMITH: No objection.

JUDGE FINKLE: Admitted.

(Exhibit P-67 admitted.)

Q (By Mr. Kelly) What are the basic conclusions of your report?

A I really have two conclusions. The first conclusion is that Premera is in a weak capital position and right now has some capital constraints.

Q And when you say "capital constraints," what do you mean by that?

A Capitally constrained means that when a company gets to a level of capital where they are approaching any either the regulatory or the Blue Cross/Blue Shield Association or their own target levels, they have to take into consideration their capital whenever they make a decision. Their decisions

cannot totally be based on what's best for the company, what's best for the customer, what's best in the marketplace. What they have to take into consideration is the fact now days risk-based capital, because that's the standard.

Q Okay. And so when you used the term "capital constraint," it's then the constraint on the decision making and actions of the company; is that what you are saying?

A Yes.

Q Now, let's talk about that. You just mentioned that first conclusion. I'd like to talk with you about that for a bit and then we'll go on to your second conclusion.

A Certainly.

Q Why is it you conclude Premera is presently in a weak capital position and must be considered capitally constrained?

A At the time of my report we were looking at the 2002 risk-based capital level, and at that point they were at 406 percent risk-based capital, which is dangerously close to the 375 percent Blue Cross/Blue Shield Association level, and lower than most plans would target, so lower than what most Blue Cross/Blue Shield plans would target for risk-based capital level.

Q Okay. Now, how does that 2002 data of 406 percent compare with the RBC levels of other Blue plans of similar companies?

A One of the lowest. We looked at 14 comparable plans, and of the 14 there were a couple that were lower, but it - most of

the plans were higher. And it's significantly lower than the average Blue Cross/Blue Shield plan, which at that time was over 600 percent.

Q Okay. And what type of targets for those other companies did they have for their RBC level?

A It's impossible to tell what all of them have for a target; you just know what they have for an ongoing risk-based capital level. The plans I work with have really looked at 500 percent as the minimum that they want to hit. Now, that's the minimum that they want to hit.

Q Well, you were talking about 2002 data. You also have some information about 2003 data?

A Yes. It's come in recently. We started to look at it. Right now Premera's risk-based capital at the end of 2003 was 433 percent, so a slight improvement over what it had been in 2002.

Q And what is your general understanding as to whether - as to what the average was for RBC levels in 2003 compared to 2002?

A It's gone up significantly. In the few plans we have looked at have gone up percent-wise that much or more.

Q Okay. And does the NovaRest report give more details regarding comparison of Premera's RBC levels to the RBC levels of other Blue plans?

A Yes, it does. It does the analysis of the 14 plans over time and their RBC level compared to Premera.

Q I think that's in the Appendix B?
A Appendix B.
Q So maybe if we can review for the commissioner briefly the overall picture. We have an RBC of 375 for a standard for the Blues; is that correct?
A Right.
Q We have Premera's 2002 level was 406?
A Mm-hmm.
Q 2003 was 433?
A Right.
Q Do you consider that a significant change?
A It's going in the right direction.
Q Better up than down?
A Yes.
Q At the same time the - for 2002, where you have more complete data, 500, as you understand it, is the target for similar companies?
A The minimum target, yes.
Q And the average in 2002?
A Was over 600 percent.
Q Okay. And then your sense also was that just about Premera's RBC went up somewhat in 2002, 2003, it was a similar increase in the average for all the other companies?
A Actually, percentage-wise from what we are seeing it's more, it's a larger percentage. Looks like the underwriting cycle

from 2002 to 2003, we are in an up cycle. Just looking at the risk-based capital, it all seems to be going up. So if you look at the underwriting cycle, it looks like it was a good year.

Q Although I don't want - because we are at the end of the day, but a little bit about the underwriting cycle, very thumbnail sketch.

A A thumbnail sketch is that the underwriting cycle is a result of health plans trying to predict what the cost of healthcare is going to be at the time they set premiums for the period of time the premiums are set for. And sometimes the predictions are more accurate than others. And it results in higher profits and sometimes losses, lower profits from year to year. And it's considered the underwriting cycle.

Actually, we'll probably get more into a description of risk-based capital, but it is the risk that risk-based capital is trying to measure, is the risk of that underwriting cycle.

Q Because if the company misjudges in its underwriting cycle and doesn't obtain premiums high enough but has higher pay-outs, is that the problem, in layman's words?

A Right. Over --

MR. COOPERSMITH: Your Honor, we would object. We'd like to have it in the form of direct instead of a leading question.

MR. KELLY: If I could just raise that question, Your Honor. I'm not clear why counsel is objecting to a leading question in this form.

JUDGE FINKLE: Well, I don't know if counsel needs to defend himself, but I think you are asking whether that objection is appropriate in this proceeding. I believe that the testimony of the witness is what's important for the commissioner to hear. And while I would tend to give more latitude than I might in a trial and I agree with you that that's appropriate, I think when it gets a bit past that line I would sustain the objection whoever makes it. Thank you.

MR. KELLY: Okay.

Q (By Mr. Kelly) Then you should describe briefly what the impact is if the company misjudges in an underwriting cycle what its premiums should be.

A You end up with underwriting losses, the down part of the cycle. And let me just take a second and tie that back to risk-based capital. Because when we develop risk-based capital, the 200 percent mark was really intended to be the level where a normal underwriting cycle - and we modeled a normal underwriting cycle - where it was the normal underwriting cycle at 200 percent, there was a good chance but not a 100-percent chance that the company would survive to a year. And it was right at that 200 percent that there started to be some question to if under normal underwriting

cycles, not extreme ones, but normal underwriting cycles, using the history of underwriting cycles at that point in time, that the company might not survive two years.

So it was a point where it was felt that regulators would have two years to get into the company and get things turned around before - before they would be responsible for the company. So, that's - the underwriting cycle is an aspect of the risk-based capital.

Q And then what is the reason, as you best understand it, why the Blue association sets a higher minimum?

A Well, there are a couple of reasons, not the least of which is that they would really want to ensure that their plans last more than two years. And so they really need a level that protects not just survival but that is a level where the company is financially sound, which would be above a survival level. So, they feel that at 375 percent that's more financially sound and gives them a buffer, if there is a problem, to send their teams in and get the company turned around.

Also, they are responsible for the Blue Cross/Blue Shield name across the country, and it's very important to them, and that's why they had a capital requirement well before the marketplace had a capital requirement, and they held their plans to a capital requirement before anyone else was subject to one. It's very important to them to protect

the name of Blue Cross/Blue Shield.

If a company in another state, Blue Cross/Blue Shield plan gets into financial problems, it causes a ripple effect across the country, and therefore affects the plans in every state.

Q Let me go back to the question about the RBC level of Premera of 406 in 2002, 433 in 2003. What's the import of Premera being so capitally constrained?

A Well, as we said earlier, one of the biggest problems of being capitally constrained is you start making decisions based upon the affect on capital instead of the good business decision of how it's going to affect your profitability, how it's going to affect your customer service, and how it's going to affect your efficiency long range. It starts making your decision making very short-range focused because it's all about how it affects risk-based capital. When you have more of a buffer, you can make investments in the future knowing that the risk-based capital level will come back up as those investments pay off.

Q Before I forget, let's get back to your second conclusion. What is the second conclusion you are making?

A Okay. My second conclusion is that - I don't know how to say this now.

Q Maybe if I can --

A Okay.

Q What observations did you have to make about the benefits and disadvantages of raising capital through a variety of sources?

A Okay. We looked at the affect of improving the risk-based capital, looking at a number of ways to improve risk-based capital, and decided that the best - and I'll define best in a second - the best way would be through the equity markets. And I would define best as would increase the capital to a prudent level most expeditiously in the shortest period of time. It would not be a one-time solution. It would be a solution that, if something beyond the normal underwriting cycle or if there was a problem in the future, that it could be used.

And third would be the overall cost, because of the affect on profits and the pressure on profits of the overall cost of raising the capital. So there are really three things that were looked at.

Q Let me pursue that area of your second conclusion a little bit further. Can you describe how capital constraints can impact a company's strategic plan?

A Well, what I've been preaching since we were developing risk-based capital is that a company, when making strategic decisions, any strategic decisions, on investment, on growth, should model its effect on risk-based capital. And I think companies are starting to do that. Life and PNC companies

had risk-based capital before health companies did. And it was my observation working with the life risk-based capital and PNC risk-based capital committee at the NAIC, that the companies were taking more of a strategic approach and looking at the effect of their strategic plan of risk-based capital.

Health companies, except for the Blues, were not - were not used to thinking that way because they didn't have capital requirements, they had deposit requirements. And I think now companies are becoming very much aware of the fact that when they make investments they have to look at, is that investment going to be admitted, how is it going to be - you know, all of the accounting and balance sheet aspects of that effect of risk-based capital.

Q What about the impact of capital constraints on the ability of a company to grow?

A Well, growth comes in three different ways, in my mind. The most obvious is population growth. Maybe it's not the most obvious. But one way is the population grows, same market share but the population is growing. When we normally talk about growth, we talk about the company getting a larger market share, they are competing better, and so they are attracting more customers.

When you talk about risk-based capital, because risk-based capital is driven by incurred claims primarily,

it's a very, very complicated formula, but I think if you boil it down to the major driver it's incurred claims. So a company can, without adding any new members, from a risk-based capital perspective, can grow, because its incurred claims will be going up because of medical inflation. So medical inflation forces health insurers to grow and forces risk-based capital to increase, even if you are not adding new members. So there's a natural growth of health insurance companies.

Q Now, you talked about the equity market being the best source of capital. What are the other potential sources of capital for a company like Premera?

A There are really four that we looked at. There's merger. There is selling of assets. There's increased profitability, you know, just adding more through your profits. And I know there are four.

Q Is there debt?

A There's debt. There's always just taking on debt, yeah.

Q Because I have the advantage of these notes here.

A Yes.

Q Let's talk for a minute about selling assets to raise capital, pros and cons, limitations.

A Okay. When you sell an asset to raise risk-based capital - first maybe I should say that when I talk about risk-based capital it's a ratio between the capital requirement that

comes out of the NAIC formula. And as I said, that's primarily driven by incurred claims, medical expense, and a company's capital. And I use the word capital, not-for-profit Blues plans often use the term reserve. And we've heard it referred to as reserve here, but because we are talking about risk-based capital, for consistency I'll call that capital. So it's a ratio of the two. So you can change either one of those and affect your risk-based capital formula. And as I said, just medical inflation will cause your risk-based capital ratio to go down if your capital isn't going up, if your company isn't growing in worth, in capital.

As far as selling assets, if you sell an asset and it's worth the same amount that it was on the balance sheet, you haven't improved your risk-based capital. So you have to sell it for more than what it was admitted on your sheet for - first to increase your risk-based capital. When you sell an asset, an asset should have, and almost always does have some affect on future profits and income. Either it's income producing or it's an asset that's allowing you to become more efficient. It's your home office building that now you don't have to rent. So it's affecting your profitability and your profits going into the future. When you sell an asset, you give that up, you give up those future profits, and then you are going to have to make them up somewhere else in order to

keep your profitability at the same level. Also, when you sell an asset it's gone, it's a one-time transaction, and eventually you run out of assets to sell.

Q Okay. Now, merger I think you said was another possible source of improving your capital position. Could you comment on that?

A Yes, I can. For a merger to improve your capital position, you have to either merge the two companies and their assets, and that rarely happens. Often they are separate. So in order to improve the capital position of company A by virtue of merging with capital - company B, some of the capital from B has to be moved to A.

It's my experience that that company wants some return, one, on that movement of capital. Two, in a merger, one of the first things that's often done in the form - a filing - reaction to the Form A filing is to restrict the flow of that capital from company to company, especially if the companies are in two different states. So, sometimes - there are often restrictions if those companies are in two different states, of being able to move that capital.

Now, over the long run you hope to have efficiencies and, you know, increased profits just because you have some efficiencies merging the two companies, using the same system. In the short run, you don't: you are going to have expenses to do all of those things. In the short run,

there's going to be expenses and reduction of capital.

Q Okay. And understandably you are focused on capital, but are there other consequences, such as impact on autonomy from a merger?

A In my experience, especially when we were looking at the solutions to Blue Cross/Blue Shield plans that had capital requirements, one of the biggest problems was the autonomy and merging two cultures, you know, saying can we bring these two cultures together; and if so, which one is going to be the one that's going to control the other, I guess is the simple way of saying it.

Q What about an alternative of taking on new debt or using what's called surplus notes?

A Surplus notes are a way to take on debt so that it does not show up as a liability on the balance sheet of the company that's taking on the debt. It was more common in the early '90s to be able to get a surplus note from the Blues plan. But if the two - if two companies, and it doesn't have to be a Blues plan, if the two companies are in two different states, there's an approval process for repaying not only the principal of that surplus note but in some cases even the interest on that surplus note. And usually the control of that repayment is with the commissioner of insurance in the state receiving the note, and therefore commissioners in states, even if the company is willing to provide a surplus

note say to Premera, the commissioner may not allow it.

Q Okay. What about trying to raise profits as a way to increase capital?

A And I will also say surplus notes are very expensive because of all of that also, I might add that.

Raising profits is a very long-term solution, it's not short term. Profit margins, even to keep up with risk-based capital, in the case of Premera I think I heard their profit margins historically have been under two percent, are going to have to go up just to keep up with risk-based capital and medical inflations. And now you are talking about increasing profits even beyond that to make up a fairly large deficit. And it certainly is nothing that can be done on a short-term basis and probably is impossible.

Q And are there other consequences even if you do raise premiums in terms of --

A Well, when we talk about raising profits, there's a lot that goes into profits. You can raise premiums. And yes, there's some consequences. You can lose customers if you start raising premiums. Or you can decrease some of your expenses, like your medical expenses, but then you start affecting your net worth and start affecting the fact that members want to go to certain doctors in the network, and again you start losing customers.

Q That brings us then to raising capital through the sale of

stock. Are there advantages that you see to a company to raising capital by going to the stock market?

A Yes. If you look at the three aspects, one, if you go to the stock market, it's immediate influx of capital. Two, and I think maybe the most important one in some respects, is that it allows you, as long as you keep the company financially healthy, it allows you to go back to the markets in the future if there is a temporary problem. You are trying to protect against - you protect the company and put it in a position where it's a position going into the future, and it allows you therefore a possible - a possibility of capital influx if there would be a problem in the future.

Because of the way capital markets work, when you get capital because of selling stock, you don't have to repay it, unlike debt. The capital markets get a return of their principal by selling the stock to someone else. Their profit comes from the fact that the company is worth more than when they bought it. You know, the economy is worth more than it was 10, 15 years ago, and individuals who invest in that participate in that growth. And again, with health insurers, they have to grow because they have to meet increasing risk-based capital requirements as long as there is medical inflation driving all of that.

Q So, final question, what is your conclusion as to the best way for Premera to raise capital?

A Looking at the four ways and looking at my three criteria, it would be going to the equity markets.

Q That's what I have. Thank you.

JUDGE FINKLE: About how long would you expect to be?

MR. HAMJE: Well, Your Honor, before I give my estimate I just want to let you know that they are notoriously bad. And in fact, I can give you an example. I've predicted, at least internally, about 45 minutes for Mr. Barlow and I think I took at least twice that long the other day. I would say it's going to be at least 30 minutes with Ms. Novak.

JUDGE FINKLE: And will you have some as well?

MR. COOPERSMITH: Your Honor, I think I can be more precise. I have one question for Ms. Novak.

JUDGE FINKLE: Is there any problem with your returning tomorrow?

MR. KELLY: That's not a problem.

JUDGE FINKLE: With your soul bearing, I think we will adjourn. We'll see you at 9:00.

MR. HAMJE: Thank you, Your Honor.

MR. KELLY: Thank you, Your Honor.

(Adjourned at 5:09 p.m.)

C E R T I F I C A T E

STATE OF WASHINGTON)
(ss.
COUNTY OF THURSTON)

I, PAMELA J. KLESSIG, a Court Reporter and Notary Public of the State of Washington, do hereby certify that the foregoing proceedings were reported by me on May 4, 2004 and thereafter transcribed by me by means of computer-aided transcription.

I further certify that the said transcript of proceedings, as above transcribed, is a full, true and correct transcript of the aforementioned matter.

DATED and SIGNED May 6, 2004.

_____

Notary Public in and for
the State of Washington,
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